# ACTIVE HEALTH REPORT

What we think. What we know. What we do.

## THE ACTIVE HEALTH REPORT – PERSPECTIVES ON CANADA'S HEALTH PROMOTION SURVEY 1985

Canada

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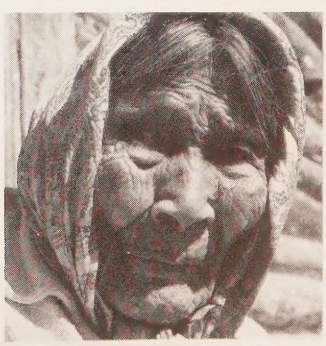
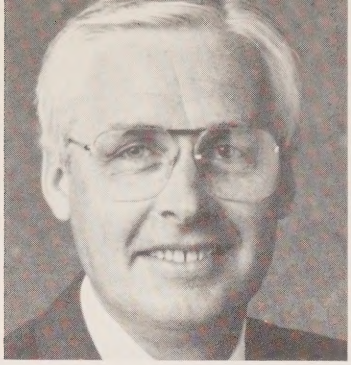
## CONTENTS







## MINISTER'S INTRODUCTION

**It is with great pride that I introduce** the *Active Health Report* . It is a ground-breaking document. It presents and discusses the results of Canada's Health Promotion Survey – the first national survey to ask Canadians how they feel about their own health. Past surveys have studied the nature and causes of people's health problems. This report from the Health Promotion Directorate offers us something new: a comprehensive picture of the health knowledge, attitudes, behaviour, and intentions of Canadians.

The findings emphasize that health is affected by social and environmental concerns as well as lifestyle and medical factors. Health is inextricably linked to the living and working conditions Canadians enjoy. The disadvantaged are much more likely to report health problems than more privileged Canadians.

Health is determined not only by individual behaviour, but also by life circumstances, relationships with family and friends, and the availability of social policies and programs that make it a priority. The title, *Active Health Report*, was chosen to highlight this complex, dynamic interweaving of individual, social, institutional, and environmental elements.

The *Active Health Report* closely reflects many of the challenges outlined in the discussion paper, *Achieving Health for All: A Framework for Health Promotion*, that I presented at the World Health Organization Conference in Ottawa last November. Both are important elements in our current effort to build a common understanding of health promotion in Canada. I look forward, therefore, to the discussion and debate this report will undoubtedly provoke. Over eleven thousand Canadians have spoken to us with frankness and enthusiasm. It will be a privilege and a challenge for us all in the health community to respond to what they have said.

Jake Epp,
Minister of National Health and Welfare

# EXECUTIVE SUMMARY

***The Active Health Report*** *is the first report on Canada's Health Promotion Survey. It reflects closely many of the ideas, concepts and challenges presented in the discussion paper,* Achieving Health for All: A Framework for Health Promotion. *The aim of the survey was to explore what Canadians think, feel, and know about health, and how these things relate to what they do. The purpose of this report is to summarize the survey's findings and to reflect upon the challenges and opportunities they imply for health promotion as we practise it. The report is divided into eight chapters, each of which concentrates upon a single aspect of what Canadians have said to us.*

**Chapter 1: How Canadians Rate Their Health**
Chapter 1 examines how Canadians perceive and rate their own health. It finds that despite pervasive health problems Canadians generally perceive themselves to be healthy: 61% rate their health as very good or excellent. The questions raised for health promotion are: Are Canadians as healthy as they think they are? And, how do we get people to improve their health if, rightly or wrongly, they think their health is already good?

**Chapter 2: Striving For Health**
Chapter 2 examines how Canadians rate their own efforts to improve their health. The findings indicate that they are making a good effort – 64% report that they make more of an effort than others their age – and that very often this is backed up by their behaviour. Furthermore, it is poor health itself that often seems to prevent people from making more of an effort.

**Chapter 3: Self-Care – Selected Health Practices**
Chapter 3 looks at selected health practices – at some of the specific things that Canadians do or fail to do to maintain or improve their health. Two key points emerge. First, for the practices surveyed, positive habits have become the social norm. This represents a great resource for health promotion because the majority groups with good habits are primary agents of social change. Second, we find that those who rate their health as poor are less likely to have positive habits. Again, poor health itself emerges as a barrier to improvement.

**Chapter 4: Making Changes**
Chapter 4 looks at the changes Canadians have made and want to make in their health habits. Sixty-seven per cent of respondents indicated that there was something they should be doing to improve their health. However, the chapter also finds that what people think they should do to improve their health, and what they actually intend to do, if anything, are often quite different.

**Chapter 5: Knowledge, Attitudes, and Beliefs**
Chapter 5 explores health knowledge, attitudes, and beliefs. It finds that they do not seem to affect health behaviour and self-rated health as much as we might expect. This suggests that health promotion campaigns should be multifaceted and not rely strictly upon information as the basis for behaviour change.

**Chapter 6: Family, Friends, and Health**
Chapter 6 looks at the way in which a person's family and friends can influence health and health behaviour. We find that the influence is very strong, both positively and negatively. Most people who persist with poor health practices have family and friends who do so as well. Similarly, people with positive health habits share them with family and friends. The findings suggest that health promotion should look beyond individuals to their close social environments in order to develop strategies and initiatives that enable people to make real changes.

**Chapter 7: Inequalities and Health**
Chapter 7 looks at the ways in which income, education, and employment status relate to self-rated health and health behaviour. We find that disadvantaged Canadians – that is, those with lower incomes, less education, and who are unemployed – are much more likely than their well-off neighbours to rate their health as poor and to have poor health habits.

**Chapter 8: What Canadians Want From Their Institutions**
Chapter 8 looks at what Canadians want from three key social institutions: schools, business, and government. It finds widespread acceptance of a role for these institutions in improving health. However, more than just information is needed. In all areas, there is a greater demand for policy and program initiatives than there is for information.

# INTRODUCTION

**The *Active Health Report* is an inter-**pretive report based on Canada's Health Promotion Survey (*see box*). The Report complements and reflects closely many of the ideas, concepts and challenges presented in the discussion paper, *Achieving Health for All: A Framework for Health Promotion.*

Canada's Health Promotion Survey was undertaken by the Health Promotion Directorate of Health and Welfare Canada, and conducted on its behalf by Statistics Canada in June of 1985. The purpose of the survey was to explore the health knowledge, attitudes, beliefs, and behaviour of adult Canadians – to find out what Canadians think, feel, and know about health, and how these things relate to what they do. This type of information is of prime importance to health professionals. Health promotion often attempts to achieve its goals by changing the health-related behaviour of Canadians. Knowledge, attitudes, and beliefs are some of the keys to the development of effective and innovative strategies and programs.

Though it shares much common ground with other work, such as the Canada Health Survey and the General Social Survey, Canada's Health Promotion Survey is the first national survey to focus on health orientation and behaviour rather than health status.

In keeping with the complex, multi-faceted nature of health behaviour, the survey was very broad. Its 109 questions covered a wide range of topics – from self-care to self-rated health, CPR training to employment, health-risk avoidance to the habits of family and friends. Its aim was not to probe individual topics in great depth, but rather to take a wide-angle view of the health orientation of Canadians and to gather the breadth of data that will allow us to explore the relationships among different aspects of health behaviour and the various factors which influence them.

This wide-angle orientation is reflected in an array of reports. Each individual report takes a different view of the data, slicing the pie in a different way. A comprehensive view of the survey's technical results will be made available in the technical report on Canada's Health Promotion Survey. This technical report is a primary resource document, intended for use in the preparation of other reports. It is expected to encourage researchers to carry out further analyses of Health Promotion Survey data. The technical report will also be published in summary form.

More detailed information on and discussion of specific health topics will be presented later in a series of satellite reports. Projected topics include: disadvantaged Canadians; youth; women; the handicapped; health in the North; the elderly; labour groups; and family, friends, and health.

In addition to these national release plans, the survey's data tapes have been given to the provinces and territories for their own investigation and research and for preparation of reports pertaining to local concerns. The tapes can be purchased from Statistics Canada.

The reports listed above all share a common orientation. They are concerned primarily with the presentation of the data gathered by the survey. The *Active Health Report,* on the other hand, takes a very different position. It focuses on health promotion itself and on what we can learn about health promotion by exploring health knowledge, attitudes, and behaviour.

The idea for the *Active Health Report* evolved out of a growing concern at the Health Promotion Directorate of Health and Welfare Canada that the traditional model of health promotion had some significant limitations. This concern was shared by many other people in the public health community and was the focus of many debates and discussions.

Traditionally, health promotion has had three main features:

1. *A problem orientation.* That is, it has tended to focus on specific health problems like overweight, or poor nutrition, or stress in isolation, often without reference to each other and without reference to the broader context of life

***Canada's Health Promotion Survey was a telephone survey*** *undertaken by the Health Promotion Directorate of Health and Welfare Canada and conducted on its behalf by Statistics Canada in June of 1985. The survey used random digit dialing technology to contact households all across Canada. The response rate was over 80%. Ultimately, over 11 000 adult Canadians aged 15 and over – nearly 1000 in each province, the Yukon, and the Northwest Territories – participated in the survey. Each of them was asked 109 questions covering 250 items of information, creating a massive database which should continue to generate useful insights for many years to come.*

*Despite its size and range, the survey had significant limitations which readers of this report should bear in mind. First, it was a survey of the* non-institutionalized *population only. It excludes those in hospitals and in chronic care homes. Second, children were excluded. Fortunately, Queen's University has completed two major studies of the knowledge, attitudes, beliefs, and behaviours of Canadian school-aged children. Copies of these reports can be obtained from the Education and Training Unit, Health Promotion Directorate, Health and Welfare Canada. Third, although it is very broad, it could not possibly have included questions on every health topic. Certain very important topics, such as dental health and sexuality, to take just two examples, were excluded. Finally, because it was a telephone survey, it excluded the 3% of Canadians who do not have telephones. While this does not greatly bias the aggregate picture, it is significant given the relationship between health and economics that the report documents.*

circumstances within which health problems arise.

2. *A focus on lifestyle.* That is, it has viewed health problems as the result of poor personal habits. Accordingly, it has attempted to improve health simply by changing individual habits and behaviour.

3. *An emphasis on the provision of information.* That is, it has attempted to change people's habits by giving them accurate and timely information about health problems. In recent years this emphasis has been changing, and health promotion has become much more multifaceted; it has come to include education, research, training, legislation, policy co-ordination, and community development. Information delivery, however, still occupies an important role in many health promotion programs.

In some areas this style of health promotion has achieved remarkable success. For example, Canadians' attitudes and habits have changed markedly over the past 15 to 20 years with respect to fitness, nutrition, and smoking. It is easy to forget now, but it was not all that long ago that it was more normal to smoke than not smoke, that healthy eating was for "health nuts" only, and that there were very few non-athletes jogging around city streets. In a relatively short time our attitudes and behaviour have changed. And to a large degree traditional health promotion has been responsible for these changes and for the emergence of personal health habits as an important concern for Canadians.

Yet as important as these successes have been, they also serve to highlight the limitations of the model and to throw into focus the problems that remain to be solved. People may be getting more exercise, eating better, and smoking less than before; they may be more concerned about improving and maintaining their health than ever before; yet for all this concern, there are still Canadians who have extensive health problems, and there is heavy use of medical services in Canada. Though many Canadians have changed their habits, there are millions still smoking, not exercising, and eating poorly. There has been a revolution in our health behaviour and in our attitudes toward health, but it has not touched all of us equally.

In order to keep improving the health of Canadians, more than an improvement in the health habits of individuals is required. Many other factors affect our health and health-related behaviour – factors having to do with our social and physical environments, with family, friends and background, with economic status, and with the institutions which govern our lives. If health promotion is to be truly effective, if it is ever to achieve its goal of good health for all, then it must develop techniques, strategies, and initiatives which address these factors. This is not to say that health promotion should forego attempts to modify lifestyles and provide useful and timely health information, but rather that we must view the health habits and attitudes of individuals within their wider social and environmental context.

The purpose of the *Active Health Report* is to use the data gathered by Canada's Health Promotion Survey to explore some of these other factors and some of the ways in which we might

respond to them. Its goal is not to provide answers, but rather to raise questions, to stimulate discussion, debate, experimentation, and innovation. Its aim is to challenge, not to solve.

To accomplish this, the report takes what might be called a "windowing" approach to the survey. Each window in a house gives a particular, limited view of the surroundings. By looking out of many windows we can build up a cumulative picture of the landscape around us. Similarly, each chapter of the report takes a limited, narrowly focused view of the survey. It concentrates on a few key points and highlights and examines the data in a particular way. Cumulatively, the chapters paint an interesting and often provocative picture of some of the problems and challenges facing health professionals and some of the limitations the traditional model of health promotion might have in dealing with these challenges.

A number of key issues appear repeatedly:

1) *Health, as viewed by Canadians, involves more than the presence or absence of disease.* In addition to recovery from disease, other central aspects of health include coping with chronic conditions and maintaining or enhancing current levels of health. And while the majority of Canadians report that they are quite healthy and that they are making an effort to remain healthy, they also indicate that there is still much room for improvement. In this regard, they have indicated that not only are there more things that they themselves should be doing, but also that they need continued help from their institutions.

2) *The factors that influence health, as Canadians perceive them, go beyond individual lifestyle behaviour.* To be sure, lifestyle does have an influence on health (and perceived health), but other factors are important as well.

One such set of factors is the actions people undertake to safeguard the health of significant others – for example, insisting that children are safely buckled in car seats, preventing friends from driving after drinking, learning first aid, or helping friends cope with physical or mental problems. Mutual aid and the influence of family and friends emerged in the survey as a major dimension of health behaviour and health status. Another set of factors understood by Canadians to influence health is life circumstances – income, education, employment. Indeed, these factors were more strongly related to self-rated health than any others the survey investigated. And finally, Canadians recognized the importance of healthy environments for health. In particular, they recognized a role for schools and the workplace in health promotion.

3) *As perceived by Canadians, health is closely linked to quality of life.* In this sense, health can be viewed in three very different ways. First, it can be seen as a critical resource for achieving other valued social goods – happiness, a good standard of living, and so on. Conversely, poor health can be a barrier to the attainment of other aspirations. Second, it can be seen as something that is affected by other aspects of quality of life – poverty, for example, can work to make health resources inaccessible. And finally, the close links between health and quality of life suggest that health is seen not just as a product of individual behaviour, but also of institutional and social arrangements.

4) *Not all Canadians have an equal likelihood of being healthy or have equivalent access to the resources required for health.* In particular, the socially disadvantaged are much more likely to be living in poor health than are others. They are much less likely to have equivalent access to information about health, to have an equal opportunity to learn important health and safety skills, or to have an equal ability to make health-related purchases.

It is not the role of the *Active Health Report* to try to solve problems or answer the challenges raised by its findings. Though this report does contain some suggestions for possible new directions, its primary aim is, as stated above, to raise questions and to stimulate dialogue and debate. It should be read with a mind open to new possibilities and challenges. ■

# 1 HOW CANADIANS RATE THEIR HEALTH

***In this first chapter we look at** perceived health. That is, we look at how Canadians see their own health. We find that Canadians generally perceive themselves to be quite healthy: 61% rate their health as excellent or very good, while only 12% consider it to be fair or poor. This perception of general good health holds for Canadians of all ages and both sexes, and even for those with serious health problems.*

*For public health professionals this creates a dilemma: How do we get people to improve their health if, rightly or wrongly, they feel that their health is already good enough?*

**Health is an elusive phenomenon,** one that is difficult to measure and to define. Although acute illness is observable and measurable, the gradual onset, of many health problems is not. And how *good* health might be measured is not clear. Because of this, most studies of the health of Canadians have focused on illness. We have been concerned primarily, and indeed quite reasonably, with recognizable problems.

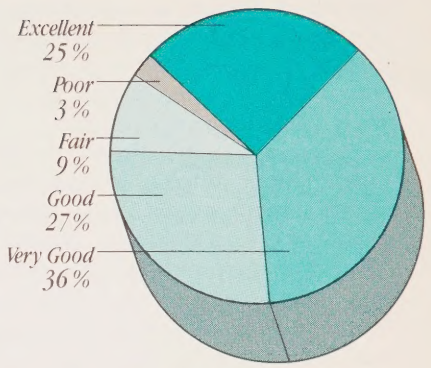
Increasingly, though, we are coming to understand that health is more than the simple presence or absence of disease or other health problems. It is, as the World Health Organization puts it, a resource for everyday living, "the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs and, on the other hand, to change or cope with the environment."

Canada's Health Promotion Survey reflects this new orientation. It did not attempt to measure health directly. Instead, its aim was to paint a picture of the health of Canadians as Canadians themselves live it and see it. Accordingly, the survey asked people to rate their own health.

Respondents were asked: *"In general, compared to other persons your age, would you say your health is excellent, very good, good, fair or poor?"*

Hard though it is for health professionals to define or measure health, respondents to the survey did not find it difficult to rate their own. Fewer than 1% of them were unable to answer.

***Fig. 1a****
***How Canadians Rate Their Health***




*Sixty-one per cent of respondents rated their health as very good or excellent. Thirty-nine per cent of respondents rated their health as only good, fair, or poor.*

Overall:
- 25% rated their health as excellent
- 36% rated it very good
- 27% rated it good
- 9% rated it fair
- and 3% rated it poor.

In short, we can say that the majority of non-institutionalized Canadians feel that they are quite healthy for their age, but many feel their health could be better. On the one hand, 61% feel that their health is very good or excellent. On the other, 39%, or nearly 8 million adult Canadians, feel that it is only good, fair, or poor.

## Self-rated Health – Men and Women

The ratings of health by men and women were virtually identical: 25% of both men and women rate their health as excellent; 3% of both men and women rate their health as poor.

## Self-rated Health and Activity Limitation

The presence or absence of serious health problems affects self-rated health, but not as strongly as one might think. People who rated their health as poor were almost certain to report

**Due to rounding off, percentages in graphs, charts and tables may not always total 100.*

activity-limiting health problems. But the opposite was by no means the case. Not all those with activity limitations rated their health as poor.

Respondents were asked: *"Are you limited in the kind or amount of activity you can do because of long-term physical condition or health problem? By 'long-term' I mean a condition that has lasted or is expected to last six months or more."*

Sixteen per cent of respondents (that is, an estimated 3.1 million Canadians) reported activity limitations. Overall, respondents who were limited in activity did rate their health as poorer than those without limitations.

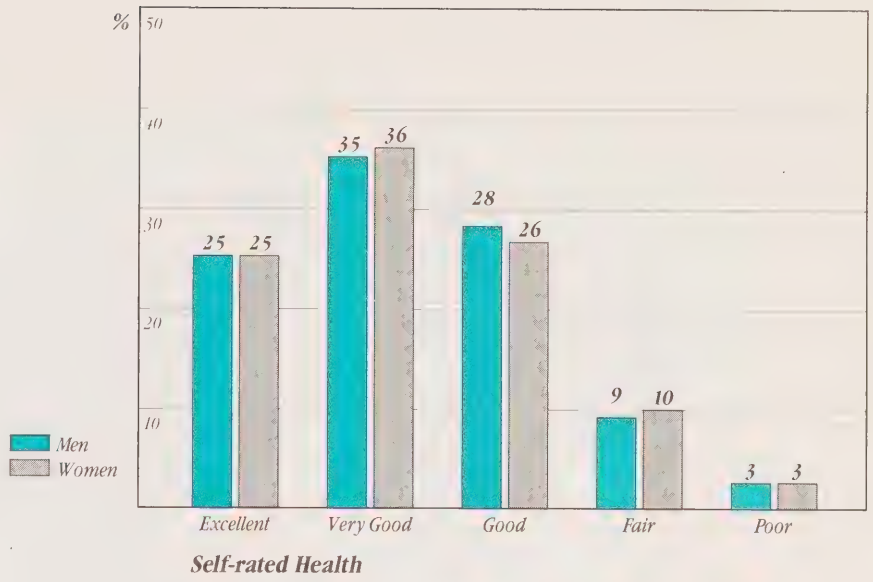
However, self-rated health did not vary as strongly with activity limitations as we might expect. While 28% of respondents with *no* activity limitation considered their health to be excellent, so did 9% of those *with* activity limitations. In fact, the majority – 60% – of people with some kind of activity-limiting health problem rated their health as good, very good, or excellent.

While those with activity limitations did not necessarily rate their health as poor, those who rated their health as poor were *almost certain* to report some kind of activity limitation.

What these data on self-rated health and activity limitation suggest is that to most Canadians good health means more than the simple absence of disease or disability. Many people *with* health problems still rate their health very good or excellent. Many of those without health problems consider their health to be far from excellent.

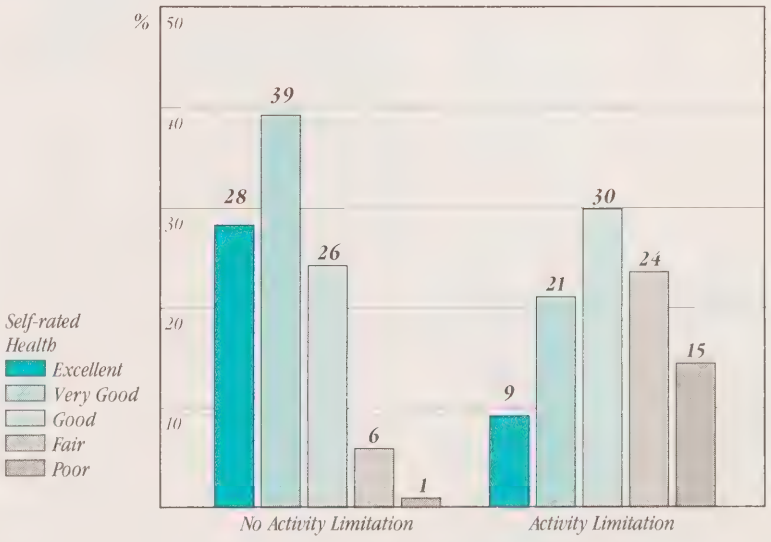
Although health problems do play an important role in determining self-rated health, other factors also have a part to play. Canada's Health Promotion Survey investigated many different factors affecting self-rated health – self-care practices (e.g., alcohol, tobacco and drug use, exercise and nutrition); health knowledge, attitudes and beliefs; the activities of family and friends; the policies and programs of institutions, and life circumstances such as income, education, and employment.

***Fig. 1b***
***Self-rated Health: Men and Women***



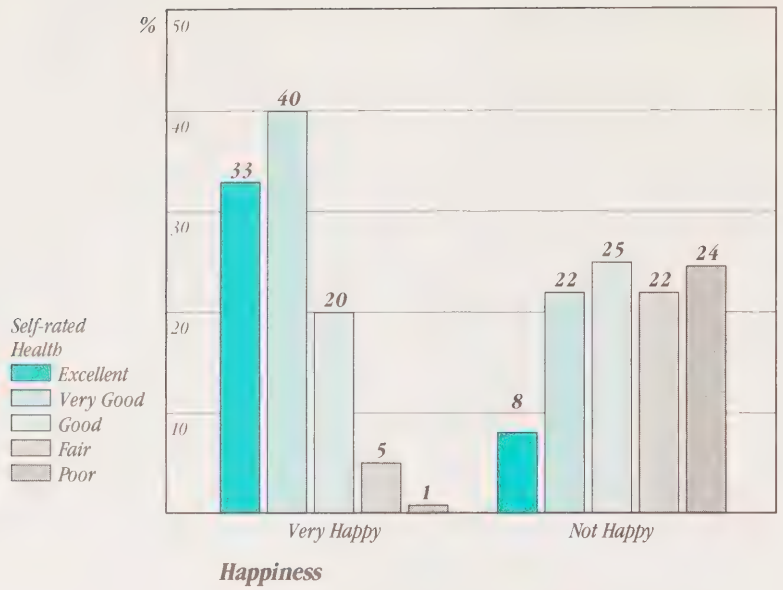

*There were no significant differences in self-rated health between men and women*

***Fig. 1c***
***Self-rated Health and Activity Limitation***




*Sixty per cent of respondents with an activity-limiting health problem still rated their health as good to excellent.*

***Fig. 1d***
***Self-rated Health and Happiness***




*Respondents who reported that they were happy were much more likely to say that their health was excellent than those who reported that they were unhappy.*

Yet, of all the factors considered in the survey, none was more strongly linked to self-rated health than quality of life. Health appears to have a strong bearing on quality of life and vice versa. Two measures were used to gauge quality of life – happiness and income.

## Happiness

Popular wisdom has it that health is the key to happiness, and happiness the key to health. The survey showed that health and happiness were strongly related. Respondents were asked: *"In general, would you say that you are very happy, pretty happy, or not too happy?"* Forty-two per cent reported themselves to be very happy, 54% said they were pretty happy, and only 4% (0.7 million Canadians) said that they were not too happy.

Among the respondents, happier people tended to rate themselves healthier and vice versa.

Of those who said that they were very happy, 33% said their health was excellent, as compared with only 8% of those who said that they were not very happy.

Conversely, of those who said their health was excellent, only 1% said they were not very happy. Among those who said their health was poor, 30% said they were not very happy.

## Income

If you are unhealthy it can be difficult to make a good income. Conversely, if you have money you have access to many resources to help improve health. The survey investigated the relationship between income and self-rated health. Respondents were asked: *"What was your household's total income from all sources before taxes and deductions for 1984?"* Five categories were recorded: less than $15,000; $15,000 - $25,000; $25,001 - $35,000; $35,001-$49,000; and more than $49,000.

Of those in the highest income group, 30% rated their health as excellent, while only 5% rated it as fair or poor. Of those in the lowest income group, only 19% rated their health as excellent, while 21% rated it as only fair or poor. ■

### *Activity Limitation and Happiness*

*It is interesting to note that activity limitations and happiness are related. Among those with no activity limitations 44% say they are very happy, while 3% say they are not too happy. On the other hand, among those reporting activity limitations, only 29% say they are very happy, while 10% say they are not very happy. Evidently, health as measured by activity limitations can be a major determinant of happiness, even if the relationship is not simple and direct.*

## ISSUES AND CHALLENGES

**1) A majority of adult Canadians say** that their health is very good or excellent. At one level this should not be surprising since these are members of the non-institutionalized population. Indeed, a major objective of health promotion is to keep people out of health-care institutions by encouraging self-care, mutual aid, and by creating healthy environments. To a certain degree these high ratings of health are consistent with the high quality of health care, health promotion and disease prevention efforts in Canada.

But the high ratings Canadians place on health also imply a major dilemma for the public health community: How do we get people to improve their health or to support the major health challenges facing the nation if they feel that their health is already good?

**2)** Intimately linked to this dilemma is the question of whether Canadians are really as healthy as they have indicated. Are their assessments valid? Unfortunately there is no simple answer to this question, since there is no generally agreed-upon method for assessing health and, by extension, the validity of self-assessment. In fact, in spite of the many studies that have been conducted, we still cannot answer the most fundamental question of all: How healthy are Canadians?

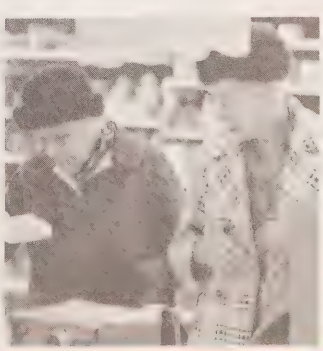
To be sure, indicators of health abound. Some of these concentrate on the extent of health problems or the use of medical services. For example, the *Canada Health Survey* reported that 54% of Canadians had at least one health problem and that 76% had consulted a medical professional in the previous year. When these figures are juxtaposed with the generally good self-ratings of health, one must ask if Canadians are overestimating how healthy they are and underestimating the likelihood that they will become ill.

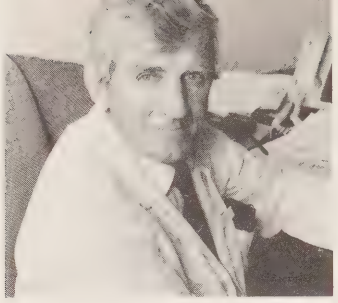
Other studies, like the Health Promotion Survey and the General Social Survey, use disability measures like activity limitation. Yet, as we have shown, many Canadians report their health as very good or excellent in spite of these handicaps. Are they overstating how healthy they really are, or is this simply evidence that people think they enjoy good health in spite of such problems; that is, they have learned to cope.

Still other studies focus on preventive factors (non-smoking, blood pressure checks, good nutrition, exercise, seatbelt use, etc.) in assessing health status. As will be discussed later, these factors often affect how Canadians rate their health, but substantial numbers persist in rating their health as excellent even though they smoke, use drugs, and may have elevated blood pressure. The effects of such factors may be chronic and slow to develop and hence may go unacknowledged by those who have not suffered acute consequences.

In sum, we are left with two kinds of information about the health of Canadians that are difficult to reconcile. On the one hand, we have evidence of extensive health problems, heavy use of medical services, and large numbers of Canadians who engage in activities known to be dangerous to their health. On the other hand, we have a population that claims to be generally healthy. Undoubtedly there are many instances in which people assess their health incorrectly. Can individual Canadians be better equipped to assess their health status accurately? Perhaps they can, but only if the public health community can develop a coherent, shared definition of health that can be communicated to Canadians in a clear and consistent fashion. It is the lack of such a definition that is at the heart of the questions and dilemmas posed above.

Whatever definition of health we finally develop, it is important that it be consistent, at least to a degree, with the ideas that Canadians themselves seem to hold. In this survey Canadians are telling us that they see health as something that is more than just the presence





or absence of disease, but rather something that is intimately connected to a wide array of other factors as well.

**3)** This apparent divergence between the health of Canadians as assessed by health professionals and the health of Canadians as they themselves report it poses a tactical problem. Should we accept their self-rating of health and focus upon health maintenance and enhancement? Or should we try to convince Canadians that they are not as healthy as they believe?

The problem-oriented approach that has characterized past health promotion efforts has tended to adopt the latter strategy. It has attempted to raise public concern and change individual behaviours as they relate to specific health problems. After all, people who mistakenly believe that they are healthy may be less inclined to undertake essential self-care.

But if people do not perceive their health to be problematic, what is the value of this approach? It seems an uphill battle to attempt to convince people that, despite what they believe, they are not healthy. From the start, this type of strategy has to battle against people's own perceptions.

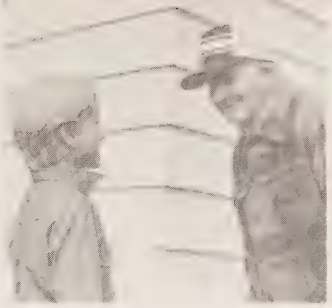
Perhaps promotional initiatives should begin, rather, by accepting those perceptions as valid and building upon them. This is the preventive approach. Instead of trying to motivate people by convincing them that they are facing danger because of their health habits, we should persuade them to maintain and enhance the good health they are currently enjoying – that is, we persuade them to avoid potential problems.

As health professionals, the question we need to ask is how we are to react in our programs and initiatives to the ways in which Canadians see their health. For whether or not their assessments are valid, they are the backdrop, as it were, against which programs and initiatives are developed. They help to determine strategies and must be taken into consideration in planning.

**4)** Finally, the linkage between perceived health and quality of life must be considered. It challenges the traditional ways of thinking about health in two ways.

First, the notion that health affects quality of life suggests that health is not only an end (that is, something that people strive for on its own merits) but a *means* as well. Good health enables and poor health inhibits the pursuit of other highly valued aspects of life – happiness and income, to name just two. (Other examples might include employment, mobility, and leisure pursuits.)

Second, the apparent effects of quality of life on health itself raise the issue of health as a social condition. Past approaches have focused heavily upon the role of individuals and institutions in achieving health but have paid less attention to the effects of other social factors and conditions. This notion of health as a social condition suggests that many of the factors that affect the health of individuals and, by extension, of populations, may arise from sectors traditionally considered outside the purview of traditional health concerns. If these factors are not incorporated into new approaches to health, the potential for improvement of the health of Canadians will be limited. ■



# 2 STRIVING FOR HEALTH

***In this chapter we turn our*** *attention from how Canadians perceive their health, to how they perceive their own efforts to maintain, enhance, or recover their health. The survey found that most Canadians think they are striving for health and that this is backed both by their behaviour and by the way they rate their health. However, it seems likely that people are not making as great an effort as they think.*

*As with self-rated health, this perception forms part of the background of health promotion. And again, two issues arise. Should health promotion initiatives accept this estimation at face value and aim to help people achieve their health aspirations? Or should they try to convince people, rather, that what they are doing is not enough?*

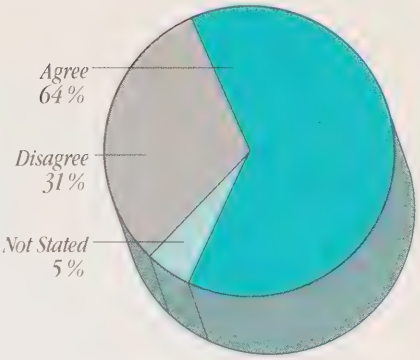
*The survey also found that one of the main obstacles that seems to prevent people from making more of an effort to improve their health is poor health itself. This suggests that health behaviour must be viewed within the larger context of life circumstances if effective health promotion initiatives are to be designed.*

**Perhaps one of the biggest changes** in our society in the past twenty years or so is the way that health has emerged as an important personal concern for Canadians. This is not to say that people haven't always been concerned about health. But never have so many people been attempting in so many ways to change and improve their health. Take, for example, the ways in which the fitness revolution and a widespread concern with healthy eating have altered our perceptions of health. It wasn't so long ago that someone who exercised or worried about nutrition was considered a little unusual. Now such concerns and activities are commonplace.

Do Canadians feel that they are making an effort to enhance, improve, or recover health? Canada's Health Promotion Survey asked respondents whether they agreed or disagreed with the following statement: *"Compared to most people my age, I make more of an effort to improve my health."*

A clear majority agreed. Sixty-four per cent of respondents said that they made more of an effort than other people their age to improve their health.

*Fig. 2a*
***Making an Effort***




*Sixty-four per cent of respondents felt that they made more of an effort than others their age to improve their health.*

This belief tells us much about how Canadians see health. Not only do Canadians want to be healthy, but they also see health as dynamic and changeable, and, implicitly, good health as something achievable. Moreover, they recognize that they themselves have a role in achieving it.

However, since a majority cannot in principle be making *more* of an effort than others their age, these results also tell us that many Canadians are likely overestimating how much they actually do to improve their health.

As the following chart shows, the reported behaviour of the respondents compares quite favourably with their stated behaviour. People who say that they make more of an effort to improve their health are more likely to report that they engage in each positive health activity. They are more likely to say that they exercise regularly, use seatbelts and other safety devices, get their blood pressure checked, have had first aid training, are knowledgeable about cardiopulmonary resuscitation techniques, and refrain from smoking and excessive alcohol consumption.

However, the differences between those who make more of an effort and

**Making an Effort and Positive Health Habits**

| | I make more of an effort... | |
|---|---|---|
| **Actual Behaviour** | **Agree** | **Disagree** |
| Exercise (3+ times/wk.) | 63% | 39% |
| Ate breakfast (all 7 days) | 74% | 63% |
| Do not smoke | 70% | 58% |
| Do not drink | 8% | 6% |
| Less than 15 drinks/wk. | 94% | 88% |
| Always use seatbelts | 67% | 61% |
| Blood pressure check (past 6 months) | 60% | 51% |
| Own first aid kit | 74% | 69% |
| Know first aid | 22% | 18% |
| Know C.P.R. | 35% | 32% |

those who do not are small for many of these activities, suggesting that there is still considerable room for improvement by members of both groups. For example, even among people who say that they make more of an effort to improve their health, it was found that:

- 37% do not get regular exercise
- 26% do not eat breakfast regularly
- 30% smoke
- 33% do not regularly use seatbelts
- 40% have not had their blood pressure checked recently.

Clearly, there is a need to continue to promote healthful activities even among those Canadians who already feel that they are making a substantial effort to improve their health. However, what is remarkable is the consistency with which people who say they make more of an effort do in fact outperform those who do not.

**Self-rated Health as a Function of Making an Effort**

| | Self-rated Health | | | | |
|---|---|---|---|---|---|
| **I make more of an effort** | **Excellent** | **Very Good** | **Good** | **Fair** | **Poor** |
| Agree | 28% | 36% | 24% | 9% | 3% |
| Disagree | 19% | 36% | 32% | 9% | 4% |

## Self-rated Health

The efforts people are making are not only reflected in their behaviour, they are also linked to self-rated health. People who say they make more of an effort report better health.

Of those who said they make more of an effort to improve their health, 28% rated their health as excellent and 3% said it was poor. Among those who felt they do not make more of an effort, only 19% rated their health as excellent, while 4% classified their health as poor. These findings suggest not only that efforts to improve health do lead to better health, but also that people perceive that they do. People feel, in other words, that their efforts are paying off.

## What Canadians Did Last Year

Respondents were asked: *"What is the single most important thing you have done in the past year to improve your health?"*

Nearly two out of three respondents (an estimated 13 million Canadians) indicated that they had done something in the previous year to improve their health.

Increasing exercise was the most frequent change that people made, being cited by 29% of respondents, followed by improved eating habits at 12%. Weight loss, quitting smoking, and getting medical treatment were each cited by 4% of respondents, while reduced alcohol and drug use, stress reduction and controlling blood pressure were each cited by less than 2%.

**Making an Effort:** Sixty-eight per cent of those who said that they made more of an effort to improve their health than others their age had actually done something in the previous year. They were more likely to have done something than those who did not report making more of an effort. Still, 54% of those who did not report making more of an effort nevertheless did *something* in the previous year to improve their health. Apparently, even many of those who feel that they are

***Fig. 2b***
***What We Did Last Year***


*Respondents were asked what was the most important thing they had done in the previous year to improve their health. Overall, sixty-three per cent of respondents reported that they had done something.*

not making more of an effort are still striving for health.

**Self-rated Health:** Self-rated health had virtually no effect on whether or not respondents had done something in the previous year. Sixty-four per cent of those who rated their health excellent said that they had done something to improve their health, as did 65% of those who rated it very good, 59% of those who rated it good, 62% of those who rated it fair, and 58% of those who rated it poor.

However, self-rated health *did* affect the *type* of action they took. Among those who felt their health was excellent, 30% said that the most important thing they did was to exercise more, followed by improved eating habits (14%), losing weight (4%), and quitting smoking (4%). But, among those who said their health was poor, the most important action taken was seeking medical treatment (23%), followed by improving eating habits (8%), increasing exercise (6%), and controlling blood pressure (4%).

These results indicate that, depending on their circumstances, people choose very different kinds of health priorities. This makes sense, yet it is something that is often unacknowledged by health professionals. People who felt that their health was excellent largely focused on activities – exercise, weight loss, improving eating habits – that helped enhance or improve their current good health. They preferred to undertake new positive activities, rather than give up old bad habits.

People who felt that their health was poor, on the other hand, concentrated overwhelmingly on the use of medical services as a health priority – that is, their priorities focused on health *recovery*.

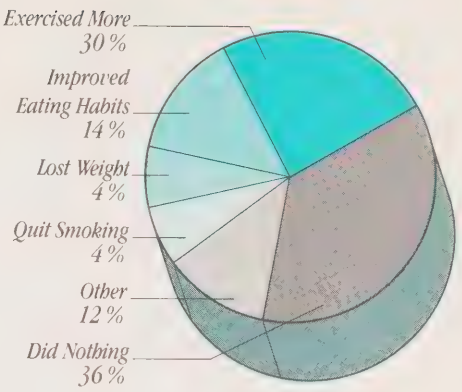
## The Non-strivers

Of greater concern than the majority who feel that they do make an effort to improve their health are the 31% of Canadians who feel that they do *not*. These people are less likely to engage in healthful behaviour and less likely to rate their health as good, very good, or excellent.

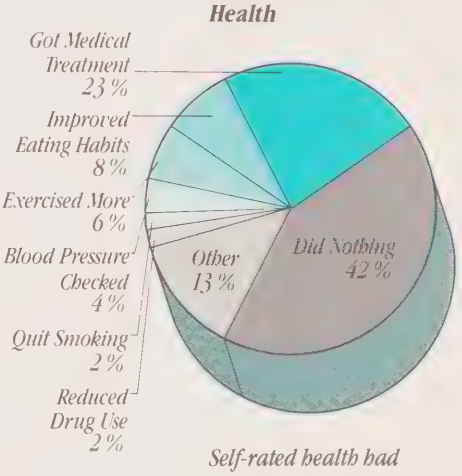
But is their poor reported health a consequence of their lack of effort, or is their apparent lack of effort a consequence of their poor health? Those who report poor health are less likely to say they make more of an effort to improve their health: a full 72% of those who report excellent health say that they make more of an effort to improve their health, compared with only 54% of those who rate their health as poor.

***Fig. 2c***
***What We Did Last Year as a Function of Self-rated Health***

***Excellent Self-rated Health***




***Poor Self-rated Health***




*Self-rated health had a marked effect on priorities for health improvement.*

**Making an Effort as a Function of Self-rated Health**

| | I make more of an effort... | | |
|---|---|---|---|
| **Self-rated Health** | **Agree** | **Disagree** | **Not Stated** |
| Excellent | 72% | 24% | 5% |
| Very Good | 64% | 31% | 5% |
| Good | 58% | 37% | 6% |
| Fair | 60% | 30% | 10% |
| Poor | 54% | 37% | 9% |

These data suggest that perceived poor health – and thus poor health itself – may be a barrier that prevents people from making an effort to improve their health. ■

## ISSUES AND CHALLENGES

**1) In Chapter 1 we saw how self-**rated health forms part of the background of health promotion and how it must be taken into account in the planning of health promotion initiatives and strategies. Similarly, the efforts that people believe they are making form part of the background of health promotion and should be taken into account as well.

This portrait of Canadians, the majority of whom feel that they are making an effort to enhance, maintain, or recover their health, is not consistent with much of the early thinking in health promotion. Perhaps this is simply because early health promotion efforts have been successful and people have changed. Whatever the reasons for current differences, the recognition that much of current poor health arose from people's habits (i.e., from their personal lifestyles) led to the conclusion that people were either ill-informed about health or that they were not sufficiently concerned or motivated to take corrective actions.

Canada's Health Promotion Survey demonstrates clearly that, to the contrary, most Canadians claim to be concerned about health and motivated to act. Yet they persist in bad health habits. The reasons for this are not well understood. They may be acting on other priorities, or they may be encountering barriers to action. Public health professionals, therefore, should not blame people for what they have not yet done to improve their health. Perhaps the most important task for health promotion is to help these Canadians achieve the healthy aspirations they already have. As well, the nearly one-third of Canadians who appear to lack the motivation for improvement must be taken into account. The design of innovative programs to reach this group will be a major challenge.

**2)** Moreover, since a *majority* of Canadians cannot, in fact, be making more of an effort than other people their age to improve their health, it is clear that despite their concern and good intentions, many are overestimating their health efforts. Once again, this creates a dilemma for health promotion: Should the public's personal estimations be taken at face value and strategies designed to help them act on their stated priorities? Or should efforts be made to convince them that, despite what they appear to believe, they are really not doing enough?

**3)** The significant minority of Canadians who do not make an effort to improve their health presents a special problem, because very often it may be poor health itself that is preventing them from making an effort to improve health or, at least, influencing their choice of health priorities. Again we are reminded that poor health practices are not simply a problem of poor motivation.

A certain percentage of these people undoubtedly do suffer physical ailments which prevent them from making an effort to improve their health. For them, recovery is a priority, as is reliance on our medical system. It is not surprising that a relatively large proportion of people who rate their health as poor list getting medical attention as their way of improving health. It should be recognized that for these people reliance on the medical system *is* a way of striving for health.

A portion of non-strivers, however, may simply be exhibiting "sick-role" behaviour – that is, they may have given up control and succumbed to a feeling of helplessness and powerlessness. To a large degree, these people have been ignored by health promotion. We must discover ways to help these people cope with their poor health, to reduce their reliance on the health care system, and to improve their health-related behaviour. In particular, we must look at the role that might be played by health promotion within the health care system itself. ■

# SELF-CARE: SELECTED HEALTH PRACTICES

***Helping people to adopt healthier practices** has for a long time been the central focus of health promotion. In this chapter we look at self-care – that is, at the things that Canadians do, or don't do, to protect, maintain, or improve their* own *health. We find that for each of the practices investigated by the survey, the majority of Canadians have positive health habits. At the same time we see that a very substantial minority still do not have positive habits and remain a cause for concern. This underlines the need to continue and to improve preventive efforts.*

*The chapter also examines the very revealing relationship between self-care and self-rated health. We find that while no one health practice has a major effect on perceived health, when a variety of practices are taken together the effect is considerable. As well, we see that many people who do not have good health habits still rate their health as excellent. Once again, this creates a dilemma for health promotion: How do we get these people to adopt better health habits if they already feel their health is excellent?*

*We also find that perceived health depends upon more than just a person's health practices. This underscores the need to look at factors other than individual behaviour that may be used to improve the health of Canadians.*

**Canada's Health Promotion Survey** questioned respondents widely on their levels of self-care. Defined broadly, self-care refers to all the things that people do to protect, maintain, or improve their *own* health. Taken in this sense the term can cover everything from the lifestyle issues, like diet, exercise and smoking, through safety to home medical care.

It is useful to divide the self-care category into two sorts of behaviour and activities that correspond to the two kinds of behavioural changes people are asked to make to improve their health. When people are urged to avoid a health risk, we are usually asking them to *give up* some well-established habit, like smoking. But when they are urged to protect or improve their health, they are more often than not being asked to *acquire* some new behaviour, like controlling their weight. The strategies used to instigate new behaviour must often be very different from those used to break old habits.

Canada's Health Promotion Survey found that in both the risk avoidance category and the health improvement category, only a minority of Canadians report poor health practices. However, this minority is still cause for concern.

## Avoiding Health Risks

The survey looked at health-risk avoidance in four categories: smoking, drinking, drinking and driving, and illicit drug use.

**Smoking:** Thirty per cent of respondents said that they smoked cigarettes regularly, and another 4% admitted to occasional smoking. Sixty-six per cent said that they did not smoke at all.

**Drinking:** Eight per cent of respondents said that they had consumed 15 or more drinks in the week prior to the survey. Ninety-two percent drank moderately — i.e., had fewer than 15 drinks per week — or not at all.

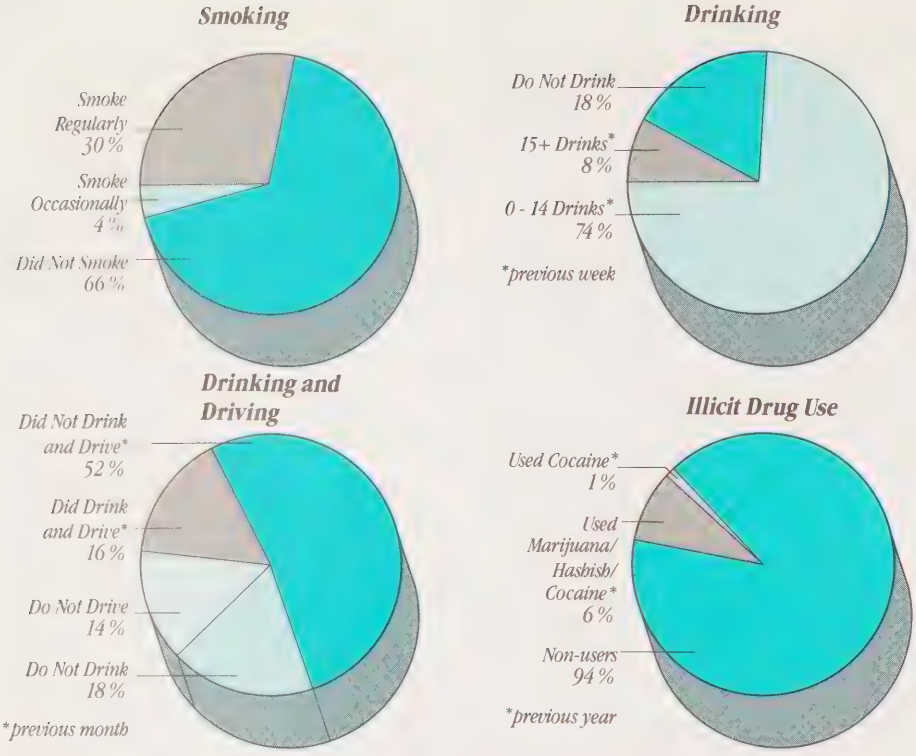
**Drinking and Driving:** Sixteen per cent of respondents said that they had driven after drinking at least once in the previous month. A very small minority of Canadians – 2.6% – who admitted to drinking and driving on five or more occasions accounted for more than one-half of all drinking-driving trips. Eighty-four per cent reported that they did not drink and drive in the previous month.

**Illicit Drug Use:** Only 6% said that they had used marijuana/hashish in the previous year, and 1% admitted to cocaine use. The overwhelming majority of those who used cocaine also reported marijuana use.

## Maintaining and Improving Health

The survey examined health protection and improvement in a variety of categories, including exercise, eating breakfast, weight control, seatbelt use, blood pressure screening, breast self-examin-

*Fig. 3a*
***Avoiding Health Risks***




*In each category health-risk behaviour characterized only a minority sub-group.*

### Seatbelt Use

*Seatbelt-wearing rates in Canada are more than double those reported in comparable studies in the United States. At the time of the survey (June 1985), eight of eleven Canadian jurisdictions had mandatory seatbelt-use legislation, while in the United States seatbelt legislation was virtually non-existent.*

ation, and PAP testing. In this chapter we look at the first four of the above.

**Exercise:** Fifty-four per cent reported exercising at least three times per week, for a minimum of 15 minutes each time; 24% reported exercising less frequently; 22% said they never exercised.

**Eating Breakfast:** Eighteen per cent said that they had skipped breakfast seven times in the previous week. Seventy-one per cent reported that they had not skipped breakfast in the previous week (just having coffee or tea was counted as skipping).

**Weight Control:** Based on height and weight, 56% of respondents were classified as normal weight, 7% were classified as underweight, and 37% as overweight or obese. Of those who wanted to change their weight, 75% aspired to a weight that was within the normal weight range for people of their height. (Note: Although overweight and underweight are not behavioural categories, they are conditions that, in part, are results of behaviour.)

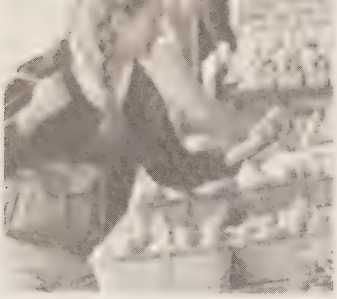
**Seatbelts:** Sixty-five per cent reported using seatbelts all the time; 13% said they used them rarely or never.

These results are both interesting and encouraging. Often, health promotion tends to look at the negative side of issues: problems become the focus, not accomplishments. Yet here, in every category, the survey shows that the majority of Canadians have positive health habits. To some extent we can conclude that health promotion initiatives encouraging healthful individual behaviour have been working.

However, looking only at percentages gives a very abstract view. Even though only minorities of Canadians persist in their poor habits, they are a significant cause for concern:

- 7 million adult Canadians still smoke cigarettes
- 2 million Canadians drink heavily
- 3 million Canadians drink and drive
- 1 million Canadians use marijuana
- 4 million Canadians say they never exercise
- 4 million Canadians usually do not eat breakfast
- 7 million Canadians over the age of 20 are overweight or obese
- 2 million Canadians over the age of 20 are underweight
- 3 million Canadians say they never wear seatbelts

Clearly, despite advances, there are still large problems to be overcome. New and innovative programs to help people improve their health practices are still widely needed. Very few Canadians have perfect health profiles; the majority have one or more negative habits. If health promotion initiatives can be credited with discouraging risk behaviour for a majority of Canadians, it must also be acknowledged that they have not yet worked for a significant minority. Understanding how they have failed for these people is a crucial task.



## Self-care and Self-rated Health

Avoiding health risks and adopting health-protective behaviour lead to better health. Given this, we might expect a strong positive relationship between good health practices and good reported health. However, the survey found that the relationship is not that clear. In fact, there was usually little difference in perceived health between those who engaged in any single health practice and those who did not.

**Smoking:** Twenty per cent of smokers said that their health was excellent, and 4% said that their health was poor. By contrast, 27% of non-smokers reported excellent health, while 3% said that their health was poor.

**Drinking:** Only 20% of non-drinkers reported excellent health, compared to 23% of heavy drinkers. Moderate drinkers were the most likely (27%) to report excellent health.

**Illicit Drug Use:** Of non-users of illicit drugs, only 25% report excellent health, while 28% of cocaine users and 20% of marijuana users report the same; 13% of non-users report fair or poor health, while only 7% of users report fair or poor health.

**Drinking and Driving:** Drinking and driving does not appear to affect perceived health. There are only small differences in self-rated health between those who drink and drive and those who do not.

Among those who engage in health-protective behaviour, the relationship is clearer – they are more likely to rate their health as excellent than people who do not engage in such behaviour. Yet the differences are very small.

**Exercise:** Of those who exercise regularly, 29% say their health is excellent, compared to 20% of those who do not.

**Breakfast:** Regularly eating breakfast is at best only mildly related to self-rated health. Among those who never skip breakfast, 26% report that their health is excellent and 36% say that it is very good. Among those who always skip breakfast, 23% say their health is excellent and 34% that it is very good.

**Seatbelt Use:** Twenty-seven per cent of those who always use seatbelts and 22% of those who never use seatbelts rate their health as excellent.

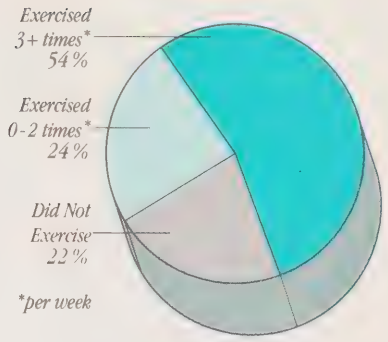
**Weight Control:** People of normal weight report slightly better health than do those who are overweight or underweight, with 29% saying that their health is excellent, 39% very good, and only 2% rating their health poor. People who are underweight are as likely as those of normal weight to rate their health as excellent, but much *more* likely (10%) to rate it as poor. Those who are overweight or obese are less likely to rate their health excellent and more likely to rate it fair or good.

There are various ways these findings can be interpreted. Some activities, such as using seatbelts, probably do not have much of an effect on the way people rate their health. As well, some poor health habits, such as smoking, may not produce health problems except in the long term. These may account for the fact that people with poor practices do not necessarily rate their health as poor. It is possible, too, that many people remain unconvinced that their behaviour is harmful or unhealthy.

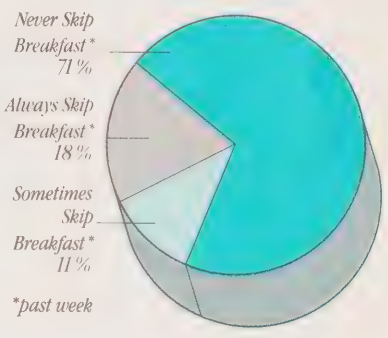
As well, we must consider that we have been looking at different health-related activities *one at a time*, as if each were the only factor that might affect a person's health. But although any individual activity, like smoking, may have enormous social consequences, its effect on the health of any given individual may be relatively small. A large number of factors, many of which are not behavioural, combine to determine our health. When self-rated health is being viewed as a function of any one specific behaviour, it should not be expected to have a clear and consistent effect.

***Maintaining and Improving Health***

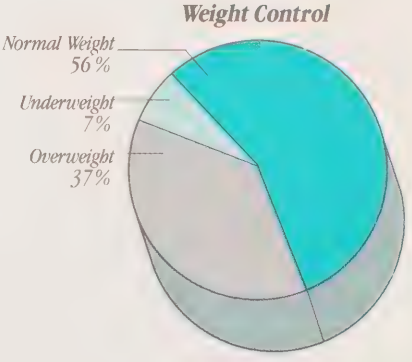
***Exercise***



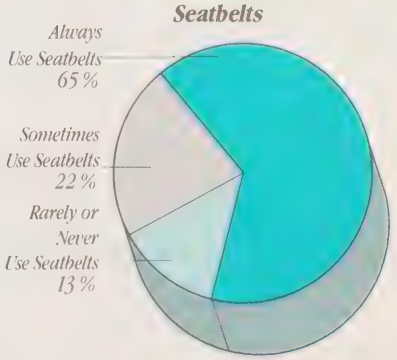

***Breakfast***




***Weight Control***




***Seatbelts***




*In each category the majority of respondents had positive health practices.*

**Self-rated Health as a Function of Health Behaviour**

| Women | Self-rated Health | | | |
|---|---|---|---|---|
| Good Health Practices | Excellent | Very Good | Good | Fair/Poor |
| 0-6 | 20% | 36% | 27% | 16% |
| 7-8 | 25% | 37% | 27% | 11% |
| 9-10 | 31% | 36% | 21% | 12% |
| **Men** | **Self-rated Health** | | | |
| Good Health Practices | Excellent | Very Good | Good | Fair/Poor |
| 0-4 | 21% | 33% | 32% | 15% |
| 5-6 | 25% | 36% | 30% | 10% |
| 7 | 34% | 38% | 20% | 8% |

*Among both men and women, respondents with a greater number of good health practices were more likely to rate their health as excellent.*

**Health Behaviour as a Function of Self-rated Health**

| Women | No. of Good Health Practices | | |
|---|---|---|---|
| Self-rated Health | 0-6 | 7-8 | 9-10 |
| Excellent | 27% | 33% | 40% |
| Very Good | 33% | 34% | 33% |
| Good | 36% | 36% | 28% |
| Fair/Poor | 41% | 28% | 31% |
| **Men** | **No. of Good Health Practices** | | |
| Self-rated Health | 0-4 | 5-6 | 7 |
| Excellent | 26% | 32% | 43% |
| Very Good | 31% | 34% | 36% |
| Good | 38% | 39% | 24% |
| Fair/Poor | 45% | 31% | 25% |

*Among both men and women, those who rated their health as poor were much more likely to have fewer positive health practices.*

### *Poor Habits and Self-rated Health*

- *20% of smokers rate their health as excellent*
- *20% of marijuana users and 28% of cocaine users rate their health as excellent*
- *23% of heavy drinkers rate their health as excellent*
- *29% of underweight, 22% of overweight, and 14% of obese respondents rate their health as excellent*
- *23% of those who always skip breakfast rate their health as excellent*
- *17% of those who never exercise rate their health as excellent.*

Indeed, when the cumulative effects of multiple health practices are examined, a much clearer relationship between perceived health and health behaviour emerges. Two scales of "good health practices" were developed, one for men and one for women. The scales comprised a slightly different set of activities and behaviour from those discussed above. For both men and women the scale included exercise, smoking, drinking, illicit drug use, nutrition, safety, and protective measures such as blood pressure checks. As well, women were questioned on three additional items relating to PAP tests and breast self-examination.

Among women, of those with up to six good health practices, 20% reported excellent health and 36% reported very good health, while of those with nine or ten good health practices, 31% reported excellent health and again 36% reported very good health.

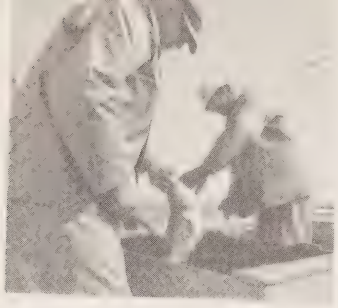
Among men, of those with up to four good health practices, 21% reported excellent health and 33% reported very good health, while of those with seven good health practices, 34% rated their health as excellent and 38% rated it as very good.

## Self-rated Health as a Barrier to Improvement

The picture is further complicated because the relationship between health habits and self-rated health works two ways. Not only do health habits affect self-rated health, but self-rated health can affect health habits.

Among men, 43% of those who rated their health excellent, but only 25% of those who rated their health poor, engaged in seven positive health practices. Among women, 40% of those in excellent health engaged in nine or ten good health practices, compared to only 31% of those reporting poor health.

The previous chapter showed that people who rate their health as poor are less likely to make an effort to improve their health than those who rate their health as good to excellent. These results show that, similarly, those who rate their health as poor are less likely to engage in a large number of positive health practices. ■



**Weight Control Out of Control?**

*Weight control is of great concern to Canadians. People who were overweight or obese were the most likely to be dissatisfied with their current weight: 93% of those who were obese and 80% of those who were overweight indicated a desire to lose weight.*

*However, not all desire for weight change was motivated by a concern for health. Fewer than one-half of Canadians of normal weight were satisfied with their current weight: 45% wanted to lose weight, while 10% wanted to gain weight. Respondents who were underweight were the most likely to be satisfied with their current weight, and 7% of them still wanted to weigh less.*

*More men (23%) than women (14%) would be overweight if they ever actually attained their desired weight, while more women (10%) than men (4%) would be underweight. These tendencies are most prevalent among men aged 50 to 59, 38% of whom would be overweight if they reached their desired weight, and among women aged 20 to 29, 18% of whom would be underweight if they reached their desired weight.*

## ISSUES AND CHALLENGES

**1) Despite the distance we still must** go to ensure that all Canadians are as healthy as they can be, poor individual health habits are no longer the social norm in Canada. In every category investigated, poor behaviour characterized only minority sub-groups.

This is significant because the majority groups who have good habits are primary agents for continuing social change. We see this happening already: it is non-smokers' rights groups that are having the greatest effect on the social acceptability of smoking, for example, and associations of people who do not drink and drive who are pressing hardest for action on impaired driving. This suggests strongly that health promotion strategies could be using prevailing social norms as the basis for further change.

**2)** Health promotion must acknowledge the complexity of the factors that affect people's self-perception and behaviour. Self-rated health, we have seen, does not vary simply with health problems or with the healthfulness of people's practices. Individual behaviour does not account for as much of health as was once expected. There are wheels within wheels that work together to determine the health and health behaviour of any individual.

In particular, we should take great care not to focus on individual behavioural factors in isolation. Many people who consider themselves healthy and who engage in a majority of positive health habits still retain some negative habits. The presence or absence of any single behaviour, this chapter shows, does not have a significant effect on perceived health. Behaviour only affects perceived health when the cumulative influence of many different practices is examined.

**3)** While poor health habits affect self-rated health, self-rated health also affects health practices. People who see themselves as unhealthy are less likely to have positive health habits. In other words, poor self-rated health may be a significant barrier to the adoption of positive health habits. And, as we have seen that those who rate their health as poor are almost certain to have some kind of activity-limiting illness or disability, we can also say that poor health itself is a barrier to the adoption of positive health practices. The people who perhaps most need to improve their habits are the least able to do so on their own. Health promotion must develop strategies and initiatives to help those whose health is too poor to help themselves. ■

# MAKING CHANGES

**Chapter 2 showed that the majority** of Canadians are striving for health and that they believe they make a good effort to improve their health.

Chapter 3 examined some of the individual actions that people take to improve their own health. We saw that even though activity by activity the majority of Canadians have good health habits, most probably retain some poor habits.

In other words, despite generally good self-care among Canadians, most people still have room for improvement and changes. This naturally raises the question of whether people intend to make these changes.

The survey approached the question of changes by asking respondents two central questions: *"What is the most important thing you feel you should do to improve your health?"* And, *"What do you intend to do next year to improve your health?"*

***In Chapter 4 we look at the changes*** *Canadians feel they should make in their health habits. We also examine the changes they say they* intend *to make to see if people actually are doing what they feel they should be doing. This kind of information is useful in designing programs that assist people in setting their priorities for changes and overcoming obstacles to improvement.*

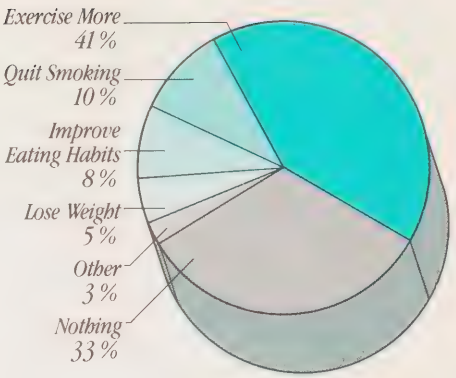
*Two significant findings emerge. First, the survey shows that what people think they should do and what they plan to do, if anything, are often very different. And second, it shows that self-rated health critically affects the kinds of changes people want to make.*

## What Canadians Say They Should Do

Respondents were asked if there was something they *should* be doing to improve their health.

Two out of three (an estimated 13 million Canadians overall) acknowledged that there is something they should be doing. Forty-one per cent said they should exercise, 10% wanted to quit smoking, 8% to eat better, and 5% said they should lose weight. Less than 1% felt they should reduce alcohol or drug use.

***Fig. 4a***
***What Canadians Say They Should Do***




*Two out of three respondents acknowledged that there is something they should be doing to improve their health.*

**Self-rated Health:** Those who rated their health as good or very good were the most likely (71% and 72%) to feel that there was something they should do to improve their health. This dropped to 64% for those who rated their health excellent.

At the other extreme, only 30% of those who rated their health as poor felt there was anything at all they should do to improve their health. In other words, those whose health is poorest are the least likely to feel that there is something they should be doing to improve it. However, as we saw in Chapter 2, quite possibly these people feel that there is little they *can* do.

## What Canadians Intend to Do

Respondents were asked what they *intended* to do to improve their health in the coming year.
(Note for graph: More than one response was allowed, so that totals are higher than 100%.)

Sixty-two per cent of respondents (an estimated 12 million Canadians) said that they intended to do something in the coming year to improve their health.

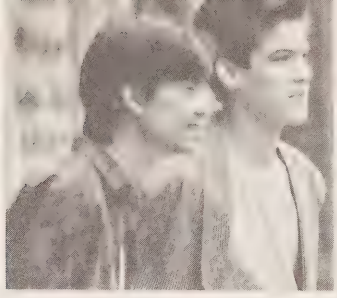
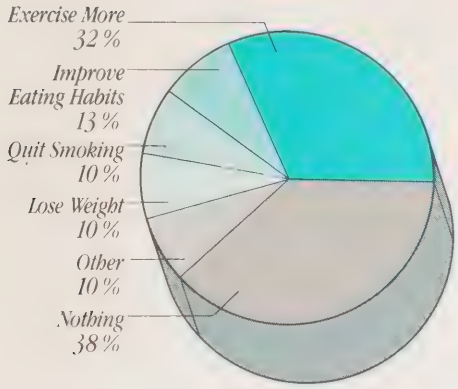


*Fig. 4b*
***What Canadians Intend to Do***




*Sixty-two per cent of respondents reported that they intended to do something to improve their health in the next year.*

Overall, what people intended to do was very consistent with what they already had done – exercise and eating habits were the most frequently cited answers to both questions. As well, people who did something in the past year were more likely (69%) to intend to do something again than those who had done nothing in the past year (52%).

**Self-rated Health:** People who rated their health as excellent and people who rated their health as poor were the *least* likely to intend to do something to improve their health in the coming year. Only 57% of the former and 54% of the latter intended to do something, compared to 64% of those who reported fair to very good health.

Once again, health priorities differed sharply with self-rated health. Perceived health status affected not only the likelihood of action, but the type of action undertaken. Of those who rated their health as poor, 46% intended to do nothing to improve their health in the following year, 15% intended to seek medical treatment (that is, their priority is health recovery, not enhancement), and only 37% intended to take some personal health-enhancing action. This contrasts with the 54% of those whose health is excellent and the 63% of those whose health is good or very good who intended to take some personal action in the following year to improve their health.

## Setting Goals

Do people intend to do what they feel they should do? Remarkably, very often they do not.

- Of those who said they should improve their eating habits, only 68% intend to do so.
- Of those who said they should reduce their drug use, only 55% intend to do so.
- Of those who said they should stop smoking, only 51% intend to do so.
- Of those who said they should exercise more, only 50% intend to do so.
- Of those who said they should lose weight, 48% intend to do so.
- And of those who said they should drink less, only 11% intend to do so.

Two out of three Canadians recognize that there is something they should do to improve their health, but only about one-half of them overall intend to make this improvement. Evidently, though people perceive a need for improvement, they also feel that there are barriers and difficulties which keep them from making these changes.

### *Intending to Quit*

*Ten per cent of Canadians said that they intended to try to quit smoking over the next year. This is quite remarkable given that only 30% smoke regularly. In other words, 33% of those who smoke intend to try to quit.*

*The question is: How many will succeed? And how can health promotion be better equipped to help people succeed?*

## Health Priorities and Poor Health Habits

This gap between what people say they should do and what they intend to do becomes even more striking when we relate it to health-risk behaviour. Many of us would likely believe that the most important thing that smokers, heavy drinkers, and drug users should do to improve their health is to quit. But smokers, drinkers, and drug users apparently don't see it that way:

**Smokers:** Among regular smokers, exercising more (at 34%) was most frequently mentioned as the thing they should do to improve their health. Quitting smoking came second at 29% and only half of this group actually intends to try to quit.

**Drinkers:** Twenty-seven per cent of heavy drinkers felt that the thing they should do to improve their health was to exercise more; 14% felt they should give up smoking; and only 3% felt they should reduce their drinking. Of these latter, only about one-tenth of respondents intend to do so.

**Drug Users:** Only 3% of cocaine users and 1% of marijuana users cited reduced drug use as something they should do. Of these, only about half intend to do so. Exercise, quitting smoking, and improved eating habits were their top priorities. ■

### *Reasons for Changing*

*People may adopt healthier habits for reasons other than just improving health. For example, peer pressure may lead them to reduce their drinking, they might quit smoking to save money, or they might exercise to look better. Canada's Health Promotion Survey asked respondents whether, aside from improving their health, there was any other reason they decided to undertake their particular health-improving activity in the previous year. More than one out of three said that there were other reasons.*

| Activity | % Citing Non-health Reasons |
|---|---|
| Reduced alcohol use | 67% |
| Lost weight | 44% |
| Reduced drug use | 42% |
| Increased exercise | 41% |
| Reduced stress | 38% |
| Quit smoking | 30% |
| Improved eating habits | 26% |
| Received medical treatment | 7% |

*The point is that a very wide range of life circumstances and other factors can affect health behaviour. It is important that these circumstances and factors be taken into account in the design of health promotion strategies and initiatives.*

## ISSUES AND CHALLENGES

**1) Perhaps the most significant find**ing that arose out of the above questions is that a gap exists between what people feel they *should* do to improve their health and what they actually *intend* to do. (We can also assume there will be a gap between intentions and action: for example, one-third of smokers intend to try to quit, but fewer actually do quit.) It seems that a fairly good job has been done of building health awareness, of informing people on health issues, and convincing people that certain activities and practices are important for their health. However, health promotion has perhaps been less successful at motivating people to act and at helping them to set personal priorities.

What seems to be indicated is that awareness by itself is rarely sufficient to change behaviour, though it is a necessary first step. Despite *knowing* what they ought to do, people often form no intention of doing it. This may be, to take just one possibility, because they do not believe it is achievable for them. Smokers, for example, may give up on trying to quit after several failed attempts. Or maybe circumstances keep them from taking action: a working, single mother of two children may have no time to exercise, even though she knows that it is something she should do.

There are many different kinds of barriers that can prevent people from doing what they believe they should be doing to improve their health. What is called for is an enabling role for health promotion that goes beyond awareness building to actually help people overcome barriers to improved health.

**2)** Closely related to the above is the question of priorities. People *think* they know what they should do. But are their decisions always well advised?

Often they are not. To take one example, we saw in Chapter 2 that a significant number of underweight people are interested in losing more weight. To take another, overwhelmingly the favoured choice of action for health improvement is to increase exercise levels. This is true among people who smoke regularly, among heavy drinkers, and among drug users. It is also true for people who *already* exercise sufficiently. In general, behaviour changes which involve positive goals for improvement, like exercising, eating better, and losing weight, are favoured over those which require a person to give up unhealthy habits like smoking, drinking, or taking drugs.

Health professionals must find ways of better enabling Canadians to make decisions and set priorities which more accurately reflect their real health needs. To do this, the Canadian public health system requires a clear statement of such priorities and a coherent set of generally agreed-upon guidelines to help people evaluate their individual health needs.

**3)** Finally, we see that different people establish different health priorities for different reasons. In particular, life circumstances such as self-rated health affect people's decisions.

This is something that is often unacknowledged in health promotion, particularly when we concentrate on single issues to the exclusion of others, when we relate to Canadians in terms of one single feature of their lifestyle. We urge people not to smoke, or to eat better, or to lose weight, without any reference to their complex real life circumstances. The ultimate effect is to chastise people for their personal practices and to put various health promotion programs in competition with each other for their time, attention, and resources.

It is important, therefore, that we learn to take the whole person into account and not just his or her health needs as defined narrowly according to our own professional concerns. Only in this way can we help people to set priorities that are appropriate and to take actions that are achievable. ■

# 5 KNOWLEDGE, ATTITUDES, AND BELIEFS

*Traditionally, information delivery has been a central focus of health promotion. It has always been felt that accurate health knowledge and positive attitudes and beliefs were the key to behaviour change. In this chapter we find that health knowledge, attitudes, and beliefs do indeed affect health behaviour and self-rated health. But we also find that, at least for the subjects investigated, they do not seem to be influencing behaviour as strongly as we might expect. This suggests that while improved knowledge is a key factor in behaviour change, it is not always sufficient by itself to instigate the kinds of changes people need most to make. Health information needs to be supported by other activities if behaviour change is to be achieved.*

**Knowledge, attitudes, and beliefs** have always been important in health promotion. Especially in early initiatives, health messages were aimed at the public in the expectation that this would somehow bring about the desired changes in behaviour and lifestyle. More recently information campaigns have been more effectively linked with other kinds of activities such as education, training, and community development in combined, multi-faceted initiatives. Nevertheless, the delivery of health information still plays an important role in many programs.

Canada's Health Promotion Survey questioned respondents widely on their knowledge, attitudes, and beliefs and then compared the responses of those who did and those who did not engage in selected health practices.

Under the category *Avoiding Health Risks* we look at:
- non-drinkers, moderate drinkers, and heavy drinkers
- smokers and non-smokers
- people who drink and drive and those who do not
- illicit drug users and non-users.

Under the category *Maintaining and Improving Health* we look at:
- normal, underweight, and obese respondents
- people who eat breakfast and people who skip it
- regular and non-regular exercisers.

Overall, it was found that knowledge, attitudes, and beliefs did tend to distinguish those who engaged in good health practices from those who did not. However, the differences were often small, and those with poor health practices often had knowledge, attitudes, and beliefs that were remarkably positive.

## Avoiding Health Risks

As the charts show, respondents who avoided health risks consistently had better knowledge, attitudes, and beliefs than those who engaged in health risks. However, the differences between the two groups were small.

**Smoking:** Though smokers tended to have consistently less knowledge and poorer attitudes and beliefs than non-smokers, the greatest difference between the two relates not to smoking as such, but rather to the rights of non-smokers. Seventy-three per cent of non-smokers and only 56% of smokers disagreed with the statement that "most non-smokers don't mind if others smoke in their presence." Sixty-two per cent of smokers believed that "people are too concerned about the health effects of sidestream smoke," compared to only 45% of non-smokers.

**Drinking:** Heavy drinkers were more likely to think that most people do not suffer health problems as a result of drinking, more likely to view getting drunk as socially acceptable behaviour, and more likely to feel that moderate drinking can be beneficial to health. Moderate drinkers are less likely to feel pressured to drink than heavy drinkers.

**Drinking and Driving:** Twenty-six per cent of people who repeatedly drink and drive believe that they can have five drinks in a three-hour period and still drive safely, compared to only 7% of those who don't drink and drive.

Drinking drivers are more likely to feel that moderate drinking can be good for your health, that most people don't suffer health problems as a result of drinking, and that they can have 15 or more drinks per week without endangering their health. Drinking drivers are substantially more likely than non-drinking drivers to feel that "most people don't mind if you get intoxicated once in a while."

**Illicit Drug Use:** Only 30% of marijuana users and 36% of cocaine users felt that occasional use of marijuana will affect a person's health, compared with 63% of non-users. Seventy-six per cent of non-users consider drug use a very important topic for government to deal with, compared with 55% of cocaine users and 48% of marijuana users.

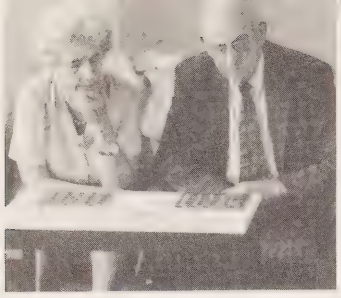
**Selected Knowledge, Attitudes, and Beliefs**

| Smoking | Smokers | Non-smokers |
|---|---|---|
| Quitting smoking after 10 years reduces health risks. | 77% | 81% |
| Women should not smoke during pregnancy. | 87% | 93% |
| Children more likely to smoke if parents smoke. | 63% | 74% |
| Smoking helps you stay slim. | 38% | 32% |
| Most non-smokers don't mind if others smoke in their presence. | 44% | 27% |
| People are too concerned about health effects of sidestream smoke. | 62% | 45% |
| It is very important for government to deal with smoking. | 43% | 59% |

| Drinking | Do Not Drink | 0-14 Drinks (past week) | 15+ Drinks (past week) |
|---|---|---|---|
| Most people do not suffer health problems as a result of drinking. | 28% | 32% | 45% |
| Most people don't mind if you get drunk occasionally. | 35% | 49% | 63% |
| Moderate drinking can be good for health. | 27% | 49% | 65% |
| On social occasions, I often feel obligated to drink, even when I would rather not. | 12% | 23% | 33% |
| I would rather pay for a taxi than see a friend drive after drinking. | 92% | 96% | 93% |
| Alcohol problems are a very important topic for government to deal with. | 72% | 72% | 51% |

| | # Drink-Driving Trips (past month) | |
|---|---|---|
| Drinking and Driving | 0 | 2+ |
| I can have 5 or more drinks in a three-hour period before I worry about my ability to drive. | 7% | 26% |
| A person can have 15 or more drinks per week without endangering health. | 6% | 14% |
| Moderate drinking can be good for your health. | 45% | 57% |
| On social occasions I often feel obligated to drink. | 23% | 31% |
| Most people do not suffer health problems as a result of drinking. | 20% | 30% |
| Most people don't mind if you get intoxicated once in a while. | 42% | 61% |
| I'd rather pay for a taxi than see a friend drive after drinking. | 97% | 95% |

| Illicit Drug Use | Cocaine Users | Marijuana Users | Non-users |
|---|---|---|---|
| Occasional use of marijuana will affect a person's physical or mental health. | 36% | 30% | 63% |
| Drug use very important problem for government programs to deal with. | 55% | 48% | 76% |



**Selected Knowledge, Attitudes, and Beliefs**

| Exercise | Exercise 3+ times/wk. | Exercise 0-2 times/wk. |
|---|---|---|
| I get as much exercise as I need. | 60% | 20% |
| I am less active than other person my age. | 9% | 34% |
| I think that getting more exercise would improve my health. | 78% | 83% |

| Eating Habits | Breakfast Eaters* | Breakfast Skippers** |
|---|---|---|
| I could improve my health by changing my eating habits. | 64% | 71% |
| Following a healthy diet is expensive and time consuming. | 24% | 32% |
| Skipping breakfast is an effective means to control or reduce your weight. | 6% | 13% |
| Eating habits are a very important topic for government programs to deal with. | 43% | 34% |

| Weight Control | Normal | Underweight | Obese |
|---|---|---|---|
| There are foods I should limit or avoid for the sake of my health. | 62% | 59% | 73% |
| There are foods I should eat more often for the sake of my health. | 66% | 59% | 67% |
| I could improve my health by changing my eating habits. | 64% | 59% | 84% |
| Following a healthy diet is expensive and time consuming. | 24% | 21% | 42% |
| I'd rather be overweight than have to give up many of the foods I like. | 6% | 7% | 17% |
| Skipping breakfast is an effective way to control or reduce your weight. | 7% | 9% | 4% |
| I need information on nutrition. | 12% | 13% | 11% |
| Eating habits are a very important topic for government to deal with. | 41% | 40% | 47% |

**Ate breakfast all 7 days in the previous week.*
***Skipped breakfast all 7 days in the previous week.*

## Protecting and Improving Health

When we look at protecting and improving health, the differences between those with poor habits and those with good habits are even smaller.

**Exercise:** Among those who exercise less than three times per week, only 20% felt that they got as much exercise as they needed, and 83% felt that getting more exercise would improve their health. Among those who exercise three or more times per week, 78% felt that exercising more would improve their health.

**Breakfast:** Those who regularly skip breakfast retain remarkably positive knowledge, attitudes, and beliefs, even compared with those who never skip breakfast. Only 13% of the skippers felt that skipping breakfast was a good way to control weight, compared with 6% of the regular breakfast eaters. Seventy-one per cent of the skippers felt that they could improve their health by changing their eating habits.

**Weight Control:** Only 4% of obese respondents felt that skipping breakfast was a good way to control weight, compared with 9% of the underweight, and 7% of those of normal weight. Eighty-four per cent of the obese, 59% of the underweight, and 64% of those of normal weight said that they could improve their health by changing their eating habits.

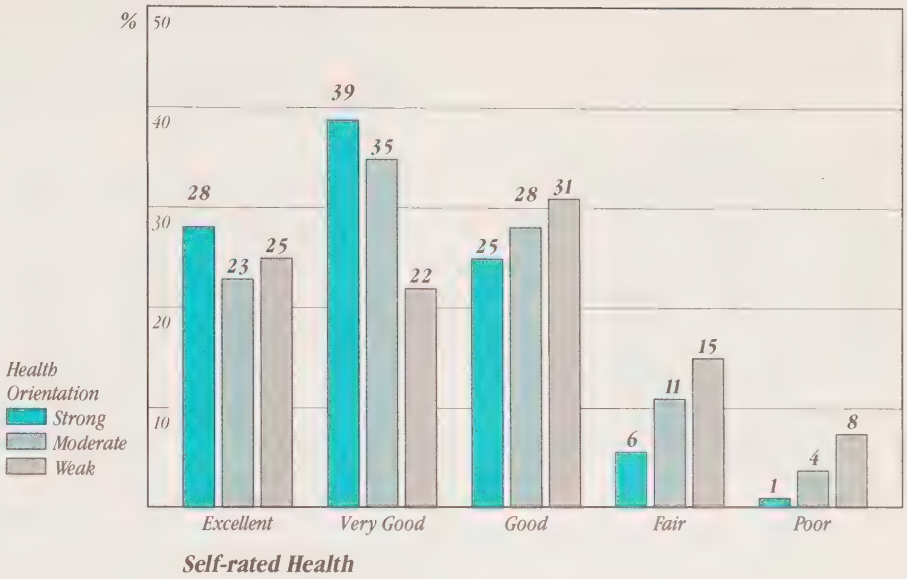
*Fig. 5a*
***Knowledge, Attitudes and Beliefs and Self-rated Health***

## Knowledge, Attitudes, and Beliefs and Self-rated Health

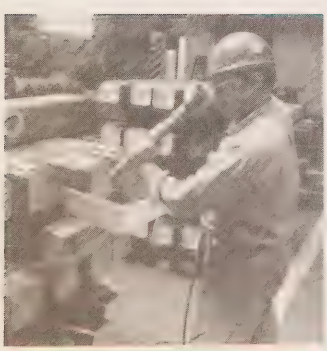
A health knowledge index was created based upon seven key health-related questions respondents were asked to answer or statements with which they were asked to agree or disagree. The questions and statements were:

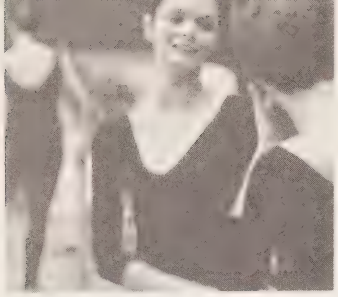
1. *You need to have your blood pressure checked only if you think you have a problem.*
2. *Children are more likely to start smoking if their parents smoke.*
3. *Women should not smoke during pregnancy.*
4. *Skipping breakfast is an effective way to control or reduce your weight.*
5. *How many drinks do you think you can have over a three-hour period before you are over the legal limit for driving?*
6. *A person who quits after ten years of heavy smoking reduces the risk of getting a disease related to smoking.*
7. *How many drinks do you think a person can have per week without endangering his or her health over the long term?*

Overall, people with six or seven correct responses were more likely to rate their health as very good or excellent than people with two or fewer correct responses, and less likely to rate their health as fair or poor. ■




*Respondents were assigned a weak, moderate or strong health orientation depending on how they answered a series of seven health-related questions. Those with a strong health orientation rated their health better than those with a weak health orientation.*





## ISSUES AND CHALLENGES

**1) While there does seem to be a** fairly consistent relationship between positive health knowledge, attitudes, beliefs, good health practices, and good self-rated health, it is not as strong as we might have expected.

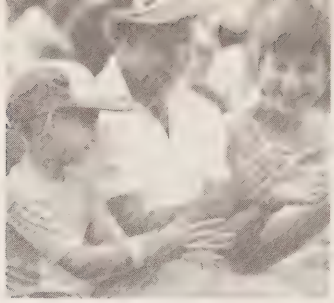
Of particular concern are those who have good knowledge, attitudes, and beliefs but still persist in poor habits. For example:

- 77% of smokers agree that quitting smoking reduces the risk of disease
- 83% of those who do not exercise regularly say that getting more exercise would improve their health
- 71% of people who regularly skip breakfast feel that they could improve their health by changing their eating habits.

These figures tend to confirm what has been learned from many early health promotion initiatives: though information is essential in instigating individual behaviour change, it is not by itself sufficient to support change. When people persist in poor habits despite knowing better, we must conclude that other factors are working as well to influence their behaviour. We will be looking at some of these factors in the next three chapters.

**2)** To a certain extent these results question the utility of campaigns which depend strictly on information to try to change health habits. Even if we were successful in accurately informing all smokers that smoking was bad for their health and that they could reduce their health risks by quitting, the chances are that all we would be creating is a population of particularly well-informed smokers, not a nation of non-smokers.

Health promotion campaigns that rely solely upon information dissemination should not be accompanied by unrealistic expectations of behaviour change. Information needs to be accompanied by other forms of action – by training and education, by group support and community action, by social consensus building. People change or persist in their habits for a variety of reasons – being well informed just helps them take the right action when they do decide to change. ■



# 6 FAMILY, FRIENDS AND HEALTH

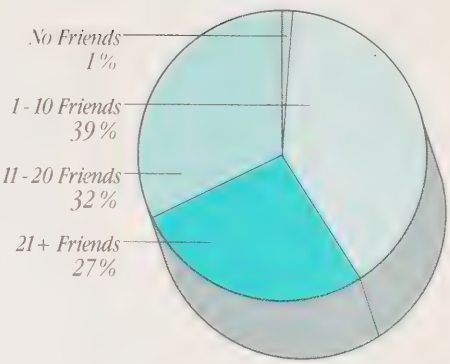
***In Chapter 6 we look at some** of the ways in which family and friends can influence an individual's health. In particular, we look at the ways in which family and friends influence health-related habits and behaviour. We find that the influence is very strong – most people who persist in poor health habits, like smoking or drinking, have friends and family who do so as well. Similarly, people with positive health habits, like regular exercise, also tend to share them with their family and friends. This is a critical fact for health promotion. We have seen in earlier chapters that people often persist in unhealthy practices despite knowing better, and often despite having intentions to change. These findings suggest that we need to look beyond individuals to their close social environment in order to develop strategies and initiatives that enable people to make real changes.*

**There are many ways in which** friends and family might affect a person's health and health behaviour. Some of these are direct:

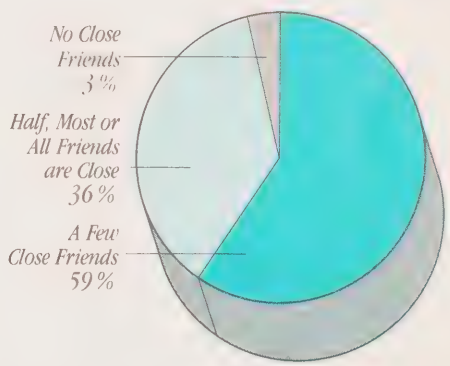
- *People intervene directly to protect others from their bad habits.* Canada's Health Promotion Survey found, for example, that 76% of respondents claimed to have intervened to prevent impaired driving when they had an opportunity to do so.
- *People may take action to protect the health and safety of those for whom they are responsible.* The survey found that 85% of Canadians who drive with children in the car always insist that the children have their seatbelts fastened or are in a car seat.
- *People may prepare themselves to care for and protect the health and safety of others.* Thirty-four per cent of respondents said they could administer cardio-pulmonary resuscitation and 21% said that they had had first aid training in the previous three years. Seventy-two per cent said they kept first aid kits in their homes, 77% that they had smoke detectors, and 50% that they had fire extinguishers.
- *People may intervene to prevent a threat to themselves from others.* Forty-five per cent of non-smoking respondents indicated that they had asked someone not to smoke around them.

As well, networks of friends can be important channels for the spread of health information and a source of direct aid in changing health habits, achieving health goals, and in recovery from illness. The lack of friends and associated feelings of loneliness, isolation, and helplessness can both affect health directly and can constitute a major barrier to health improvement.

***Fig. 6a***
***How Many Friends Do You Have?***




***How Many Close Friends Do You Have?***




*Fifty-nine per cent of respondents said that they had a few close friends to whom they could talk if they needed help or had problems. Thirty-six per cent said that at least half of their friends were close friends.*

The survey asked respondents two related questions concerning friends. First: *"About how many people, including relatives, do you consider to be your friends, that is, people you see socially on a regular basis?"* And second: *"How many people do you consider to be your close friends, that is, people you could talk to if you needed help or had a problem?"*

Evidently Canadians are a friendly people – respondents reported an average of 20 friends, and less than 1% said they had no friends. Thirty-nine per cent said they had one to ten friends, 32% said they had 11 to 20 friends, and 27% said they had more than 20 friends.

A large majority also reported having close friends that they could talk to if they needed help or had a problem. Fifty-nine per cent said they had a few close friends and 36% said at least half of their friends were close friends who could help them. Only 3% said they had nobody they could talk to if they needed help or had a problem.

Friends and family can influence health *indirectly* through knowledge, attitudes, beliefs, and, most important, health practices. How we think about health, the attitudes we maintain, the information we have on health issues, the health practices we engage in – all of these are strongly influenced by what our friends and family think, feel, know, and do. The behaviour and actions of close friends and family are major components of the social reality within which individuals enact their quest for health and thus have an important effect on health itself.

In order to paint a picture of how the people closest to us affect our health behaviour, Canada's Health Promotion Survey compared the health habits of respondents with the health habits of their close friends and, if they were married, with the health habits of their spouses. In most categories it was found that the behaviour of friends and family strongly influenced the respondent's own behaviour.

## The Influence of Friends

### Smoking

If *none* of a person's friends smokes, the chances are less than one in ten that he or she will smoke.

If *most or all* of a person's friends smoke, the chances are six in ten that he or she will smoke.

In total, a person with smoking friends is almost seven times more likely to smoke than a person with no friends who smoke.

### Heavy Drinking

If *none* of a person's friends drinks too much, the chances are only about one in 25 that he or she will be a heavy drinker (that is, have more than 15 drinks per week).

If *most or all* of a person's friends drink too much, this rises to one chance in three.

In total, a person whose friends are heavy drinkers is nine times more likely to drink heavily than a person whose friends are not heavy drinkers.

### Marijuana Use

If *none* of a person's friends uses marijuana, it is a near certainty (odds of one in a hundred) that he or she will not use marijuana.

If *most or all* of a person's friends use marijuana, the chances rise to one in two that he or she will use marijuana.

In all, a person whose friends use marijuana regularly is 53 times more likely to use it than one whose friends do not use it.

### Drunk Driving

People who at least once in the last year have been in the company of a friend who was too drunk to drive are nearly twice as likely to drive after drinking than are people who have not been in the company of potentially impaired driving friends.

### Exercise

If *most or all* of a person's friends exercise regularly, the odds are about eight

out of ten that he or she will exercise regularly too.

If *none* of a person's friends exercises regularly, the odds drop to only four out of ten that he or she will exercise regularly.

Overall, a person is twice as likely to get regular exercise if his or her friends get regular exercise.

## The Influence of Family

### Smoking

A person with a spouse who smokes cigarettes is 2.5 times more likely to smoke than a person whose spouse does not smoke.

### Spouses and Marijuana Use

A person whose spouse uses marijuana is 42 times more likely to use it than a person whose spouse does not use marijuana.

### Spouses and Tranquillizer Use

A person whose spouse uses tranquillizers is five times more likely to use them than one whose spouse does not use them.

### Spouses and Exercise

A person whose spouse exercises regularly is 1.5 times more likely to exercise regularly than a person whose spouse does not. ■

### Friends and Smoking

| How many of your friends smoke cigarettes? | Do You Smoke? Yes | No |
|---|---|---|
| None | 9% | 91% |
| A few | 22% | 78% |
| About half | 44% | 56% |
| Most or all | 60% | 40% |

### Friends and Heavy Drinking

| How many of your friends would you say drink too much? | I drank (last week) 15+ drinks | 0-14 drinks |
|---|---|---|
| None | 4% | 96% |
| A few | 9% | 91% |
| About half | 17% | 83% |
| Most or all | 36% | 64% |

### Friends and Marijuana Use

| How many of your friends use marijuana regularly? | Have you used marijuana/hashish? (past year) Yes | No |
|---|---|---|
| None | 1% | 99% |
| A few | 13% | 86% |
| About half | 45% | 55% |
| Most or all | 53% | 47% |

### Friends and Impaired Driving

| Have you been with a friend or relative whom you thought had too much to drink to drive safely? (past 12 mo.) | Have you driven after drinking? (past month) Yes | No |
|---|---|---|
| No | 13% | 87% |
| Yes | 24% | 76% |

### Friends and Exercise

| How many of your friends exercise regularly? | Do you exercise? 3+ times/wk. | 0-2 times/wk. |
|---|---|---|
| None | 39% | 61% |
| A few | 47% | 53% |
| About half | 62% | 38% |
| Most or all | 81% | 19% |

### Spouses and Smoking

| Does your spouse smoke cigarettes? | Do you smoke cigarettes? Yes | No |
|---|---|---|
| No | 22% | 78% |
| Yes | 54% | 46% |

### Spouses and Marijuana Use

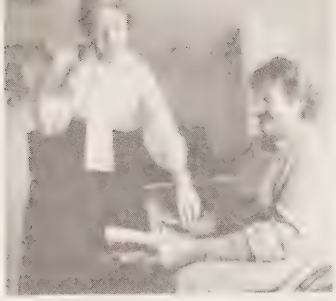
| Does your spouse smoke marijuana? | Have you used marijuana/hashish? (past year) Yes | No |
|---|---|---|
| No | 1% | 99% |
| Yes | 42% | 57% |

### Spouses and Tranquillizer Use

| Does your spouse use tranquillizers? | Have you used tranquillizers? (past year) Yes | No |
|---|---|---|
| No | 5% | 95% |
| Yes | 25% | 75% |

### Spouses and Exercise

| Does your spouse exercise regularly? | Do you exercise? 3+ times/wk. | 0-2 times/wk. |
|---|---|---|
| No | 40% | 60% |
| Yes | 60% | 40% |



## ISSUES AND CHALLENGES

**1) Few of the areas studied by** Canada's Health Promotion Survey have provided as clear a picture as this portrayal of the influence of friends and family on individual health-related behaviour. In every category, the behaviour of friends and family strongly influenced the behaviour of respondents. Simply, people tend to do what their friends do – they tend to conform to the norms of behaviour within their immediate social environments. Smokers, for example, live in a social environment of friends and family in which smoking is the norm. Exercisers tend to live in a close social environment within which exercise is the norm. Our social relationships strongly condition and reinforce our health-related behaviour and, very likely, our knowledge, attitudes, beliefs, and intentions.

How does this occur? Do friends and family condition the adoption of certain types of behaviour? This does seem to be the case, for example, when teenagers begin smoking. Or do people who share certain types of behaviour tend to seek each other out as friends? This may be the case among users of illicit drugs. Understanding which mechanism is most influential for any given type of behaviour can help us to design more appropriate and more effective programs.

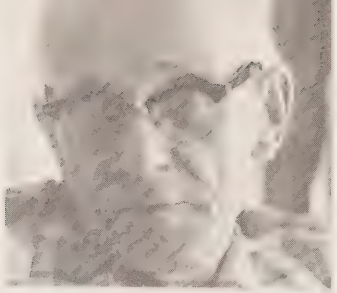
Either way, the results in this chapter indicate that we must re-think what we mean by healthy lifestyles. In health promotion, the term "lifestyles" has tended to be defined in terms of individual behaviours. The data in this chapter indicate, however, that lifestyles might be better thought of as patterns of social relationships which give rise to certain types of individual behaviour.

**2)** This shift in the understanding of lifestyle has extremely important consequences for health promotion. It means that health promotion must emphasize the social environment much more in the design of programs. Too often, health promotion initiatives are aimed at individuals without regard for their social environment. This works for some people. Yet we have seen already in this report that things aren't always so simple. Very often people persist in their bad habits and fail to adopt good ones despite knowing better, even despite real intentions to change. The profound effect of peer influences and social environment evidently plays a role here.

Given this, we should no more expect a drug user who is surrounded by friends who use drugs suddenly to give up drugs than we should expect a non-user who is surrounded by friends who are non-users suddenly to start taking drugs. We must be very aware that when we ask people to give up smoking, drug use, heavy drinking, and so on, we are not just asking people to change a habit, we are asking them to change a major aspect of their social life. We cannot expect people to change if we do not take this into account.

**3)** This is not to say that social conditions have only a negative influence, or only work as a barrier to change. They can also be a resource for change. Just as peer influence can prevent a person from making changes, it can also support individual change when group norms are changing at the same time. This suggests that we must develop programs and initiatives aimed not just at individuals, but at groups. We should try to work with the social environment instead of ignoring it. The model of individuals making rational health decisions for and by themselves, uninfluenced by their friends and family, must be replaced by a more appropriate view of health behaviour that takes into account the interactions of people within their social environments.

In particular, we must learn to tap the potential for change inherent in each person's network of friendships. The influences that friends have on each other form a tremendous resource for health promotion. Moreover, even from the very brief sampling given in this chapter, it seems that Canadians accept the notion that there is more to good health practices than the actions that individuals take on their own behalf: the actions we undertake with and on behalf of others are also seen to be important. Networks of friends already operate, in effect, as informal *health* networks in many ways. Increasingly, as emphasis in health promotion is put on mutual aid programs and initiatives, health professionals will need to develop programs and initiatives which address these networks. ■



# 7 INEQUALITIES AND HEALTH

***Chapter 7 looks at income, education,*** *and employment, and at the ways in which they relate to self-rated health and health behaviour. These social and economic factors are of interest to us because they can influence an individual's ability to achieve good health by affecting such things as living and working conditions, access to health information, health practices, and the affordability of health purchases.*

*We find that all three have a strong influence. Lower-income Canadians, less-educated Canadians, and unemployed Canadians are all more likely than their more well-off neighbours to rate their health as poor and to have fewer positive health habits. This raises a very important question: Are all Canadians equally equipped with the resources they need to achieve good health?*

**This chapter picks up where the** previous chapter left off, but with a change of focus. Instead of looking at the immediate social environment, we widen our view to look at three larger social and economic factors that can affect an individual's health: income, education, and employment. These are important, not only in their own right or by virtue of the ways in which they directly affect health, but also as indicators of the wider web of life circumstances and social relationships which can influence health.

Each of these factors can be related to health in a variety of ways.

**Income:** A good income can make health-related purchases like nutritious foods and safety equipment easier. Conversely, a poor income makes it difficult to make these purchases. At the extreme, a low income compromises health by making impossible the purchase of good food, adequate housing, and other necessities of life.

Just as income affects health, health affects income. Good health can make it easier for a person to earn a good living, while poor health can make it hard for a person even to earn a living at all.

**Education:** Education can be a resource for health – good education can provide people with the knowledge and skills required to make healthy decisions. Lack of education can influence health by limiting earnings, or by limiting access to health information. Poor health can influence education by limiting people's ability to improve their education.

**Employment:** Unemployment can influence health by causing stress, low self-esteem, and feelings of depression or helplessness. It also restricts income and hence the resources available for health purchases. Poor health, on the other hand, can limit a person's ability to work or to find suitable employment.

However, the aim of this chapter is not to try to understand the ways in which income, education, and employment may or may not *cause* good or poor health. Causality is not the question here. Rather, we are trying to paint a picture of everyday realities as they are lived by different groups of Canadians.

## Income

Canada's Health Promotion Survey asked respondents: *"What was your household's total income from all sources before taxes and deductions for 1984?"* Respondents were divided into five income groups – up to $15,000; $15,001 to $25,000; $25,001 to $35,000; $35,001 to $49,000; and over $49,000.

Overall:

- Canadians in the lowest income bracket are three times more likely to rate their health as poor than those in the highest income group.
- Canadians in the lowest income bracket are also three times *less* likely to rate their health as excellent than are those in the highest income group.

An examination of specific aspects of lifestyle and behaviour reveals other significant differences between low-income and high-income groups:

- Low-income Canadians feel they are making as much of an effort to maintain or enhance their health as high-income

***Fig. 7a***
***Self-rated Health as a Function of Income***

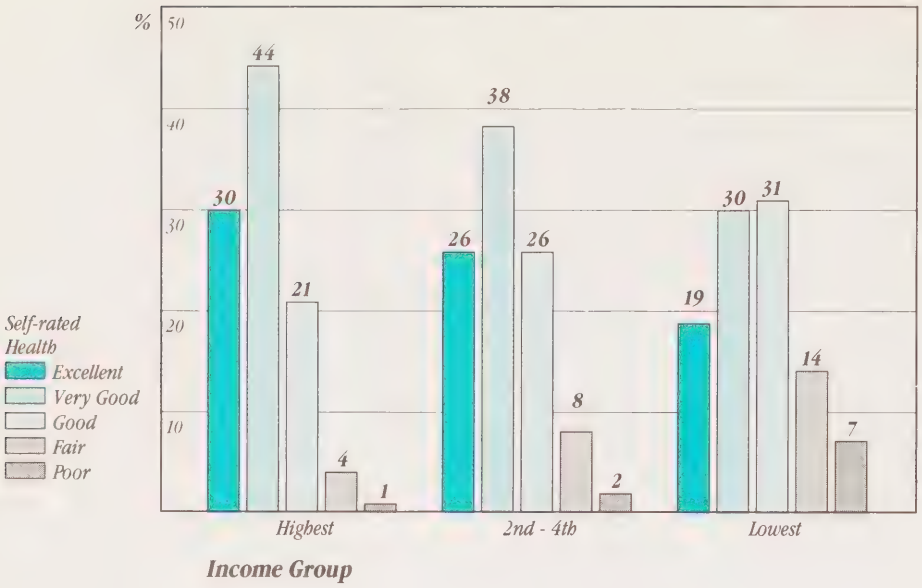



***Fig. 7b***
***Income as a Function of Self-rated Health***


*Health affects income and income affects health. Canadians in the lowest income group are more likely to rate their health as poor than those in higher income groups. Conversely, those who rate their health as poor are more likely than others to be in the lowest income group.*

Canadians. However, they are much less likely to feel that there is something they should do to improve their health. They are also less likely to say that there is something they intend to do in the next year to improve their health. Possibly, this is because low-income Canadians perceive greater barriers in the way of improvement than do those with higher incomes.

- Overall, low-income Canadians do not appear to have poorer health habits than higher-income Canadians. If anything, the reverse is true. High-income earners are more likely to drink heavily, to drink and drive, to use marijuana, and to report high levels of stress. Lower-income people use more tranquillizers, get less exercise, and have their blood pressure checked less frequently.
- Low-income Canadians are less likely to have first aid training, be knowledgeable about C.P.R., have home safety devices, or use seatbelts themselves or car seats for their kids.
- Low-income Canadians encounter more barriers to health than do upper-income Canadians – they are much more likely to be unemployed and poorly educated, and their friends are more likely to smoke and less likely to exercise regularly. They are much more likely to be exposed to side-stream smoke in their workplace, and less likely to have received health information in the workplace.

## Education

Eighteen per cent of Canadians who have less than secondary education report their health as excellent, while 20% say that their health is only fair or poor. Among those with post-secondary degrees or diplomas, 32% say that their health is excellent, and only 7% say that it is fair or poor. Overall:

- Canadians with a good education are almost twice as likely to rate their health as excellent as Canadians with poor education. Those with poor education are three times more likely

to rate their health as only fair or poor.

- Canadians who rate their health as excellent are more than twice as likely to have post-secondary education than those who rate their health as poor, who are two times more likely to have had a limited education.

Once again, these differences in self-rated health are reflected in differences in lifestyle and behaviour.

- Those with less than secondary education feel that they make as much of an effort to improve their health as those with degrees and diplomas; however, they are substantially less likely to say that they should be doing more to improve their health, or that they intend to do something to improve their health.
- Those with secondary education do not have appreciably better health habits than those with poorer education. The better-educated people are substantially more likely to drink and drive, while the less-educated people are more likely to smoke, eat poorly, and not exercise. This is reflected in the habits of their friends also. Less-educated people are more likely to have friends who smoke and get inadequate exercise but less likely to say that their friends drink and drive.
- Those with lower levels of education are less likely to have acquired important health skills in first aid or cardiopulmonary resuscitation. They are also less likely to own such health and safety devices as a first aid kit, smoke detector, fire extinguishers or car seats for their children.
- The effects of lower levels of education can be seen in other aspects of their life circumstances as well. They are more likely to report that they have a low income, that they are unemployed and that they are not very happy. If working, they are more likely to be exposed to sidestream smoke at work and less likely to have received health information in their workplace.
- People with less education are less likely to feel that they need health information than those who are better

***Fig. 7c***
***Self-rated Health as a Function of Education***

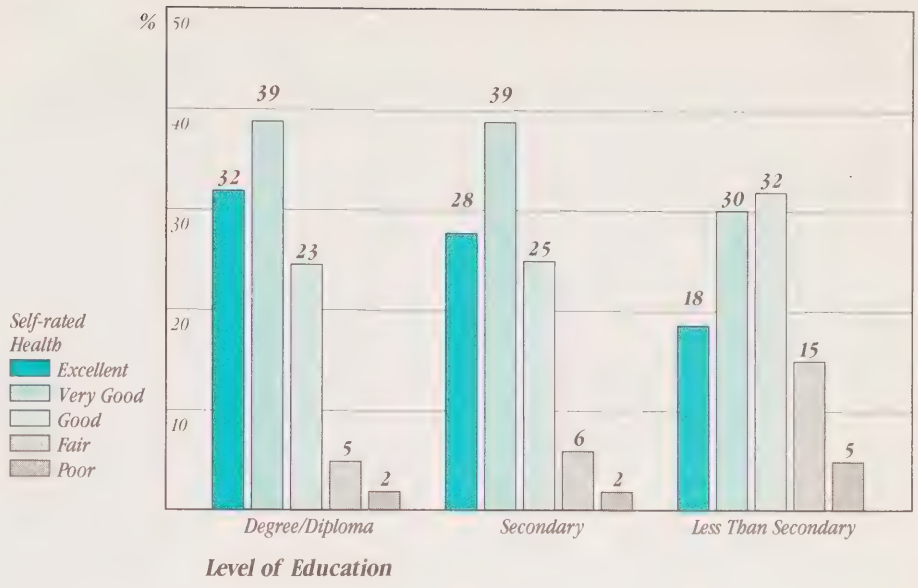



***Fig. 7d***
***Education as a Function of Self-rated Health***


*Health affects income and income affects health: those with less than secondary education were more likely to rate their health as poor than those with more education. Conversely, those with poor self-rated health were more likely to have less than secondary education.*

***Fig. 7e***
***Self-rated Health as a Function of Employment***

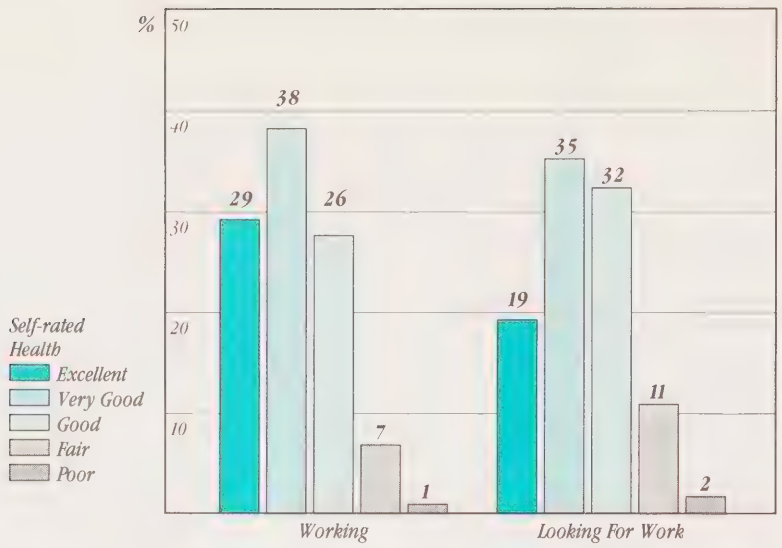
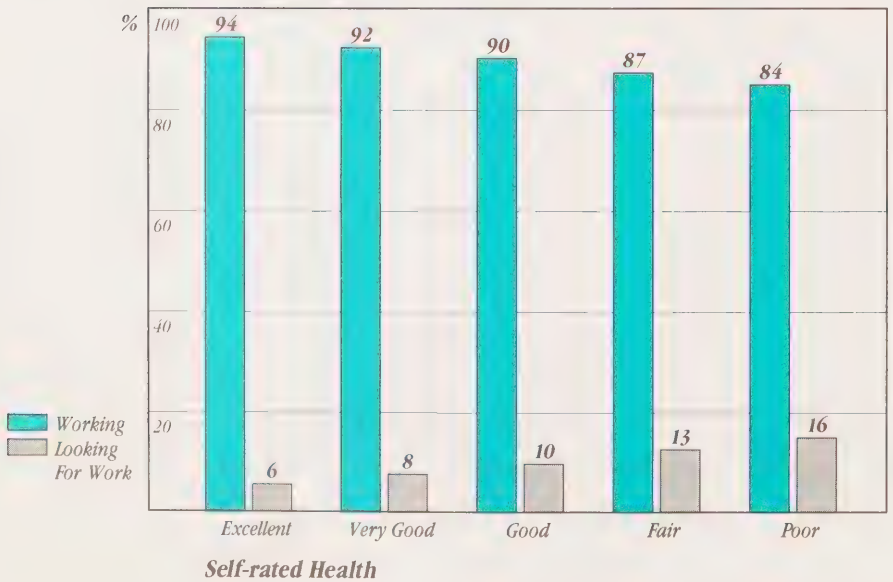



***Fig. 7f***
***Employment as a Function of Self-rated Health***




*Health affects employment status and employment status affects health. The employed were more likely to rate their health as excellent than those who where looking for work. Those with poor self-rated health were more likely to be looking for work.*

educated. Perhaps this is because the well educated place a greater value on information, know better how to use it, and have the personal and financial resources to do so.

## Employment

Canada's Health Promotion Survey asked respondents whether they were currently employed or looking for work. Overall:

- People who report that they are working are one and a half times more likely to say they are in excellent health than people who are unemployed.
- People who say they are unemployed are one and a half times more likely to report only fair or poor health than people who are employed.

Conversely, health has an effect upon employment. People with poor perceived health are almost three times more likely to be unemployed than people with excellent perceived health.

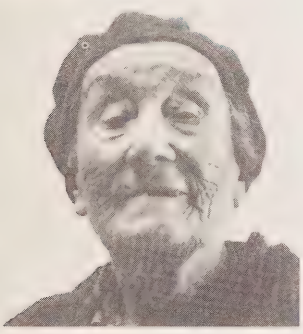
Because these figures do not include those who are unemployed and have given up looking for work, the real differences between the employed and the unemployed are likely to be even greater.

These differences in self-rated health between the employed and unemployed show up in differences in behaviour and lifestyles.

- In spite of the fact that the unemployed say they make more of an effort to improve their health, they have appreciably poorer health habits than those who are employed. The employed do drink and drive more often than the unemployed (perhaps because they can better afford alcohol or are more likely to own a car) and are more often overweight than the unemployed. On all other counts, however, the unemployed are likelier to report poorer health habits than the employed.
- Unemployed people are less likely than the employed to feel they should be doing more to improve their health but *more* likely to say they intend to do something about it. Because of

their life circumstances, however, they may face greater barriers than the employed in carrying out their good intentions.

- Not surprisingly, given their life circumstances and the barriers they face, unemployed people are less likely than the employed to say they are happy. The unemployed are also more likely to have friends who smoke, use marijuana, and drink too much, and less likely to have friends who exercise regularly. ■



## ISSUES AND CHALLENGES

**1. This section demonstrates a** strong relationship between life circumstances and perceived health. We find that income, education, and employment status are intimately related to a person's perceived state of health. As well, perceived health affects a person's ability to achieve other basic needs and aspirations. Those who report poor health are more likely to be poorer, less well-educated, or unemployed.

These tendencies occur despite fairly small differences in personal health habits between the rich and poor, the poorly educated and well educated, and the employed and the unemployed. *This is not to diminish the importance of individual behaviour in determining health, but rather to say that a person's social and economic environment is extremely important as well.*

Even the best of health habits cannot always compensate for social and economic disadvantages.

**2)** Given the importance of social and economic factors, the question for health promotion is: To what extent can meaningful improvements be made in the health of disadvantaged Canadians by using health promotion approaches? A related question is: Are major improvements in the life circumstances of the disadvantaged a prerequisite for improving their health, and if so, are there ways these life circumstances can be altered to make them more supportive of health?

At a minimum, bold and innovative approaches will be required. To start, there must be an explicit recognition that the implications of social policies often go beyond matters of economics or social welfare. They have implications for the health of Canadians as well. Health professionals must be prepared to participate in the broad planning of social programs in order to be able to improve the health of *all* Canadians, and not just of those who are well off.

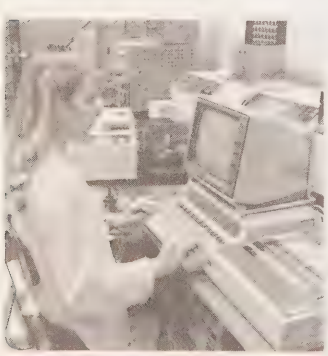
As well, because of the close link between health and the quality of life, and because health *is* a resource for everyday living, it must be recognized that health policies themselves have wider social implications.

**3)** Finally, we must understand that depending on their social relationships and economic circumstances, Canadians are more or less likely to be healthy, and more or less likely to require preventive and treatment services.

Whether or not inequities in health can ever be completely eliminated may be, to some, a matter for debate. Nevertheless, pursuing the elimination of inequities by enabling informed self care, by strengthening mutual aid and by creating healthy environments must be considered a priority. ■

# WHAT CANADIANS WANT FROM THEIR INSTITUTIONS

***We act in three ways to maintain** and improve health – as individuals through self-care, with others through mutual aid, and as a society through our institutions. Canada's Health Promotion Survey inquired into the perceptions Canadians have of three types of institutions: schools, business, and government. It found that the public perceives two important roles for institutions. First, they are seen as providers of information that can help them to live healthily. Second, they are seen as providers of policies and programs that can help them to maintain their health. The survey reveals enormous support for these institutional roles, especially the latter.*



**Various institutions have for a long** time played an important role in promoting health in Canada. Among the most significant have been federal, provincial, and local health agencies. Government agencies have been widely involved in promoting positive health practices among Canadians, delivering health information, enacting health legislation, maintaining our medical system, and many other forms of direct and indirect health promotion. But government is by no means the *only* source of health promotion. Schools, businesses, labour organizations, community groups, the media, and especially volunteer health organizations have all been taking active roles.

The wide involvement of our most significant institutions in health promotion serves to underscore that there is more to health than simple lifestyle decisions.

Canada's Health Promotion Survey investigated the support that Canadians give to Canada's health promotion role of their institutions in three critical areas: information delivery, health promotion at school and in the workplace, and action by government.

## Information Delivery

Up-to-date and accurate information is the basis for sound individual decisions about health.

The survey asked respondents: *"Are there health topics about which you feel you need more information?"* In total about 21% of the respondents – which projects to an estimated four million Canadians – felt that they needed more information on one or more health topics.

When respondents were asked on which specific health topics they wanted information, nutrition led the list, followed by high blood pressure, safety, mental health, smoking, alcohol, and marijuana.

**Canadians Wanting Health Information**

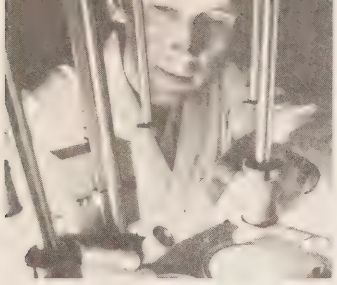
| Topic | % | Estimated No. |
|---|---|---|
| Nutrition | 11% | 2.3 million |
| High blood pressure | 10% | 1.9 million |
| Safety | 9% | 1.7 million |
| Mental health | 8% | 1.5 million |
| Smoking | 5% | 1.0 million |
| Alcohol | 4% | 0.8 million |
| Marijuana | 4% | 0.8 million |

All together, over four million Canadians felt that they need information on one or more health topics. While this reflects a substantial demand for information, it should also be remarked that this indicated that there are more than 15 million adult Canadians who felt there were no health topics on which they needed information.

This result needs to be treated with a certain amount of caution. It does not imply, for instance, that these people do not *require* health information. They may have a need for information of which they are unaware. Nor does it mean that as new health information is made available no attempt should be made to deliver it.

The results do suggest, however, that information ought to be carefully directed. For example, while only 11% of all respondents requested information on nutrition, this group was made up of particular sorts of people, with specific needs and problems. Of all those who requested information on nutrition:

- 17% indicated that they should



change their eating habits or lose weight
- 24% intended to change their eating habits in the next year
- 13% intended to lose weight in the next year
- 60% perceived themselves to be overweight, and 12% underweight
- 22% said that their spouses overate
- 33% said that following a healthy diet would be expensive and time-consuming
- 57% considered eating habits to be a very important subject for government to deal with.

Similarly for smoking. Of all those who requested information on smoking:

- 23% intended to quit smoking in the next year
- 59% reported that at least half of their friends smoke
- 53% said that their spouses smoke
- 47% said that they should learn how to improve the ways in which they cope with stress
- 59% felt that smoking is a very important topic for government to deal with.

Our examples indicate that much of the desire for information on specific topics comes from people who have intentions to change their health habits. Perhaps if more people had formed intentions to change their health practices in particular ways, the demand for information might be much greater.

## Health Promotion at School and in the Workplace

Canadians not only need health information, they very strongly support an active role for social institutions in promoting health. Respondents were asked whether they thought schools and the workplace were appropriate places to promote health:
- 90% felt that schools were an appropriate place, 6% felt they were not, and 4% had no opinion
- 68% felt that work was an appropriate place, 24% thought not, and 8% had no opinion.

While there was less overall support for health promotion in the workplace than in schools, this support varied widely with the occupation of respondents, the size of organization, and the particular economic sector in which they worked. Business people and those in managerial positions in larger companies were most likely to support the idea. Moreover, support was quite strongly related to current health promotion programming: employees of organizations that *already* provided health-related information are more likely to perceive their workplace as appropriate for health promotion. Canadians working in lower-paid, blue-collar jobs were the least likely to have received health information at work and the least likely to feel that the workplace is an appropriate place for health promotion.

## Action by Government

Respondents were read a list of ten health topics and asked to rate on a scale of one to ten how important they thought it was for government to deal with each topic. A rating of one to three signified "not very important," and a rating of eight to ten signified "very important."

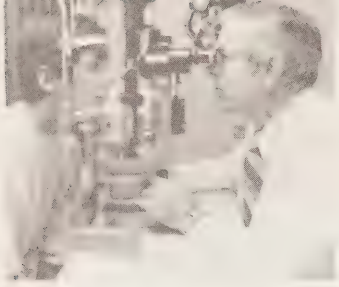
The results indicate strong support for a prominent government role in health promotion. In every topic area the demand for some kind of government action surpasses the demand for personal information. The topics which were rated lowest in importance for government to deal with – eating habits and high blood pressure – ranked highest in terms of information needs. In contrast, two topics which ranked low in terms of information need – alcohol and marijuana use – ranked highest in terms of importance of government action. This indicates perhaps that demands for government action may be precipitated by information in the first place and that information is central in making people aware of health issues, in achieving social consensus of these issues, and in mobilizing support for healthy public policies. ■

**Approval of Health Promotion in the Workplace**

| | Approved Workplace Health Promotion |
|---|---|
| **Industry/Sector** | |
| Business and misc. services | 93% |
| Durable manufacturing | 76% |
| Community services | 71% |
| Transportation/ communications/utilities | 70% |
| Agriculture | 70% |
| Other primary | 69% |
| Wholesale trade | 67% |
| Non-durable manufacturing | 64% |
| Finance/insurance/real estate | 62% |
| Public administration | 60% |
| Construction | 54% |
| **Size of Organization** | |
| Less than 10 employees | 55% |
| 10 - 49 employees | 60% |
| 50 - 100 employees | 60% |
| Over 100 employees | 72% |
| **Occupation** | |
| Managerial/professional | 75% |
| Other white collar | 67% |
| Blue collar | 65% |

**Action by Government**

| Topic | Not Very Important | Very Important |
|---|---|---|
| Accident prevention on the road | 3% | 78% |
| Drug use | 5% | 74% |
| Child health | 3% | 72% |
| Alcohol problems | 5% | 70% |
| Accident prevention at work | 6% | 61% |
| Mental health | 4% | 60% |
| Smoking | 11% | 54% |
| Accident prevention in the home | 10% | 48% |
| High blood pressure | 10% | 46% |
| Eating habits | 14% | 40% |



## ISSUES AND CHALLENGES

**1) There is very strong support** for institutional initiatives on health promotion – support that amounts almost to a demand. Moreover, this support is not restricted to government – both schools and the workplace were seen as appropriate channels for health promotion. It will be a challenge for public health professionals to open institutions to health initiatives – particularly institutions which, unlike schools and the workplace, are less in the health mainstream. However, the effort ought to be made while there is still broad acceptance of institutional initiatives by Canadians.

**2)** Since those who already had health promotion programs at work were far more likely to approve of them, further workplace initiatives will probably pay off in terms of increased receptivity for health promotion among employees.

In particular, new efforts are needed to reach lower-paid, blue-collar workers in smaller companies. Most health promotion programs to date have concentrated on white-collar managerial workers in larger companies, perhaps because these employees are easiest to reach. However, unless we develop initiatives which reach all classes of employees, we run the risk of creating a two-tiered system of employee health promotion, with the greatest and best efforts being concentrated among those who perhaps need them the least.

**3)** The fact that a majority of respondents said they did not need more information on health topics in no way implies that health information campaigns should be curtailed, but it might mean that a shift in emphasis may be warranted. We do not know the reasons for this response. Perhaps the respondents felt they already knew enough about the topics in which they are interested or that they are inundated with irrelevant information and do not want more of it. Perhaps those who have no intention of changing their behaviour are tired of receiving material which they consider preaches at them.

To overcome these difficulties, information campaigns should be better tailored to specific audience needs. In addition, information should be provided positively, in the form of recommendations and suggestions, not as imperatives or demands. There may be a need to focus upon other elements than the basic provision of information, such as the development of skills that enable individuals or groups to deal with risk problems.

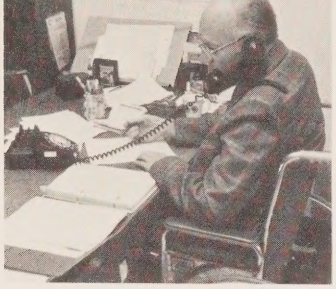
The survey data suggest that the major effects of information dissemination may be reflected less in individual behaviour changes than in making people aware of health issues, achieving social consensus on these issues and mobilizing support for healthy public policies. Excellent examples of this, all of which are supported by findings from the survey, are the current demands for action on impaired driving, illicit drug use and smoke-free workplaces.

4) While information on various health topics is still important to and needed by many Canadians, the demand for information reported in the survey is not as great as the support for policy and program action.

Such action can take many forms:

- It can take the form of *legitimation* – as, for example, when government recognizes non-smokers' rights groups or other health advocacy organizations.
- It can take the form of *legislation* – against impaired driving, say, or the illicit use of dangerous drugs.
- It can take the form of *mediation* – between the conflicting interests of smokers and non-smokers, for instance.
- It can take the form of *leadership* – as in the creation of viable health and health promotion policies.
- It can take the form of *protection* – as in increasing direct efforts to get drunk drivers off the road.

Whatever form initiatives take, it is important that we be able to respond to a public demand for health promotion efforts that go beyond a demand for simple delivery of health information. ■



# FINAL REFLECTIONS

**We have attempted to provide a broad** overview of health as perceived and practised by Canadians and of the factors that can influence the health status of the adult, non-institutionalized population. While any attempt to cover such a large population in a single report must oversimplify the picture to a certain degree, the single factor that permeates any discussion of the health of Canadians is the inherent complexity of the topic.

What this portrayal highlights, above all, is that health depends on many things other than individual self-care and the treatment of health problems – although both have major roles to play. Health also involves mutual aid, friends helping friends, and the creation of healthy environments. It involves individuals, friends, communities, health professionals, institutions, schools, businesses, and governments. In short, it involves all Canadians – many of them acting in widely varying capacities.

In some regards we have moved a long way from the realization that health is heavily dependent upon the activities of individuals. In other ways the move has been more subtle. We have moved beyond a consideration of what individuals can do for *themselves* to consider as well what individuals can do *for and with others* – as friends, as parents or relatives, as employers, teachers, community workers, or as health professionals.

In sum, then, the portrait that emerges is one of a nation that considers itself to be generally healthy and is striving to remain that way. At the same time Canadians have indicated a need for major improvements, not only in their personal health practices, but also in the social and environmental conditions that can affect their health. ■